ARH1.0001230098

Name	Mr. T RAVI		
Patient Identifier	ARHIP55450	**Age**	40Yr 0Mth 7Days
Sex	Male	**Date of Admission**	20-Apr-2022
Date of Discharge	21-Apr-2022		
MLC No			
Address	GODAVARIKHANI,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

ACUTE INFERIOR WALL MIOCARDIAL INFARCTION WITH LOWER RESPIRATORY TRACT INFECTION

H.no 7-1-424

55455

ARH1.0001229981		**Name**	Mrs. KALAVATHI MADISHETTI
Patient Identifier	ARHIP55455	**Age**	71Yr 0Mth 11Days
Sex	Female	**Date of Admission**	21-Apr-2022
Date of Discharge			
MLC No			
Address	H.NO:18-4-198,MARUTHINAGAR,GODHAVARIKHANI,PEDDAPALLY,Other,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 5
Primary Consultant	Dr SOMASHEKAR K(MS		

CORONARY ARTERY DISEASE, LMCA DISEASE+TVD+HYPOTHYROIDISM +S/P AWMI

SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PLV] DONE ON 22/04/2022.

C/o retrosternal chest pain a/w sweating since 1 day

K/c/o HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 71 years old female patient Mrs. KALAVATHI MADISHETTI presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, LMCA DISEASE+TVD+HYPOTHYROIDISM +S/P AWMI, SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PLV] DONE ON 22/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, CONCENTRIC LVH, MILD MR, MODERATE TR/PAH, MILD LV SYSTOLIC DYSFUNCTION, NO PE/CLOT/VEG

BMI is 24.1 kg/m2.

Sr. Creatinine report on 23.04.2022 1.2 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. THYRONORM 25 MCG TWICE DAILY AT 8AM 8PM BBF TO CONTINUE.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH TSH REPORT

ARH1.0001230331	**Name**	Mr. POCHAVENI RAJAM			
	Patient Identifier	ARHIP55514		**Age**	60Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	27-Apr-2022
	Date of Discharge				
	MLC No				
	Address	thanagalapalli,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATRIOVENTRICULAR NODAL REENTRY TACHYCARDIA

R/F : ALCOHOL , DENOVO T2DM

CORONARY ANGIOGRAM (27/04/2022) -CAD-DVD (MODERATE LAD, RCA), LEFT DOMINANT SYSTEM

ADV: MEDICAL MANAGEMENT

C/o retrosternal chest pain a/w profuse sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old male patient Mr. POCHAVENI RAJAM came with c/o retrosternal chest pain a/w profuse sweating since 1 day. All necessary investigations were done and diagnosed as **ATRIOVENTRICULAR NODAL REENTRY TACHYCARDIA**, R/F : ALCOHOL , DENOVO T2DM, CORONARY ANGIOGRAM (27/04/2022) -CAD-DVD (MODERATE LAD, RCA), LEFT DOMINANT SYSTEM, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. DILZEM SR 90MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. CAVERYL 2 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. GEMER 1 ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. NIKORAN 5 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ADVISED TO CONSULTANT ELECTROPHYSIOLOGIST LATER

ARH1.0001230269	**Name**	Ms. LALITHA EDMALAPELLY			
	Patient Identifier	ARHIP55501		**Age**	62Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	25-Apr-2022
	Date of Discharge				
	MLC No				
	Address	PURANI PET,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE , ACUTE AWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 27/04/2022 – CAD-SVD (LAD)

PLAN CABG WITH LIMA TO LAD.

R/F : T2DM, HTN

C/o chest pain since 3 days

At Admission

Afebrile

PR: 80/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 62 years old female patient Ms. LALITHA EDMALAPELLY came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 27/04/2022 – CAD-SVD (LAD), PLAN CABG WITH LIMA TO LAD. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ZORYL MF2 850 MG ONCE DAILY AT 8 AM TO CONTINUE.
5. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001229406	**Name**	Mr. PARAMKUSAM VENKATESHWARLU			
	Patient Identifier	ARHIP55498		**Age**	58Yr 0Mth 30Days
	Sex	Male		**Date of Admission**	25-Apr-2022
	Date of Discharge				
	MLC No				
	Address	laxmipur,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:118 C
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATYPICAL CHEST PAIN, SR

NORMAL LV SYSTOLIC FUNCTION

TMT POSITIVE (29/03/2022)

CORONARY ANGIOGRAM (28/04/2022) -MID LAD MILD DISEASE

ADV: MEDICAL MANAGEMENT

C/o chest pain since 3 months

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 72/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. PARAMKUSAM VENKATESHWARLU came with c/o chest pain since 3 months. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION, TMT POSITIVE (29/03/2022), CORONARY ANGIOGRAM (28/04/2022) -MID LAD MILD DISEASE, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.

3. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230280		**Name**	Mr. MALLESHAM KUSUMA
Patient Identifier	ARHIP55507	**Age**	83Yr 0Mth 2Days
Sex	Male	**Date of Admission**	26-Apr-2022
Date of Discharge			
MLC No			
Address	siricilla,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 4
Primary Consultant	Dr. RAMCHANDER TORREM		

SEPSIS WITH MULTI-ORGAN FAILURE ON MECHANICAL VENTILATOR

Shortness of breath grade 3 to 4 on arrival
Multiple episodes of loose stools since 1 day

Known case of ? hypertension and diabetic mellitus

AT ADMISSION:

Afebrile

PR: 110/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 84%

P/A: Soft, BS+

Treated with

INJ.PAN
INJ. HEPAMERZ
INJ. KCL
INJ.HUMAN ACTROPID
INJ.REVSTER
INJ.RENODEX
INJ.ZENCSDT
INJ.LEVIPIL
INJ.GLUTAONE
INJ.NOREDRNALINE
INJ.METROGYL
TAB CUDCE FORTE
TAB KETOCHECK
IV FLUIDS

A 83-year-old male patient MALLESHAM presented to the Emergency with complaints of shortness of breath grade 3 to 4, on arrival multiple episodes of loose stools since 1 day and altered sensorium for 6 hours, on arrival into ER patient BP was not recordable and connected to INJ. NORADRENALINE. Patient developed 1 episode of seizures, in view of poor GCS patient was intubated and connected to mechanical ventilator. Neurophysician consultation taken and advised followed. 2 cycles of renal replacement therapy (SLED) were done as patient has oligoanuria. All necessary investigations were done and diagnosed as Sepsis with multi-organ failure on mechanical ventilator. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230361		**Name**	Mr. K SAIKUMAR REDDY	
Patient Identifier	ARHIP55523		**Age**	26Yr 0Mth 1Days
Sex	Male		**Date of Admission**	27-Apr-2022
Expired Date	28-Apr-2022			
MLC No				
Address	NARAYANAPUR KOHEDA SIDDIPET,Medak,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 7
Primary Consultant	DR. SRI KARAN UDDESH -- INTERNAL MEDICINE		**Consultants**	

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
	P

PARAQUAT POISONING, ACUTE KIDNEY INJURY.

Alleged history of consumption of paraquat poisoning around 400 ml at 4:30 p.m. on 27/04/2022
C/o oral and throat ulcers , Shortness of breath, Irritability and pain abdomen

AT ADMISSION:

Patient tachypenic, obeys commands
PR: 137/min

BP: 130/80 mmHg

RS: B/l lower lobe cracles

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft, BS+

A 26 years old male patient Mr. K SAIKUMAR REDDY presented with above complaints. Patient presented with the above-mentioned complaints patient was immediately started on haemoperfusion for paraquat consumption. Patient was given INJ. SODIUM BICARBONATE patient was started on INJ. SODIUM BICARBONATE infusion patient condition was explained to the attenders. Patient was treated with INJ. DEXA INJ. Vitamin C INJ. GLUTATHIONE and IV fluids. on 28/04/2022 at 12.30 PM patient had sudden cardiac arrest, emergency intubation was done and connected to mechanical Ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, inspite of best effort return of spontaneous circulation could not be obtained, hence patient was declared as dead at 01.05 pm on 28/04/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ARDS WITH PARAQUAT POISONING

PatientDetails

UHID	ARH1.0001229603	**Name**	Mrs. D YELLAVVA
Patient Identifier	ARHIP55444	**Age**	50Yr 0Mth 25Days
Sex	Female	**Date of Admission**	20-Apr-2022
Date of Discharge			
MLC No			
Address	.,Sircilla,Telangana	**Ward/Bed No**	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,		

CORONARY ARTERY DISEASE+TVD+MYOCARDIAL ADHESIONS+S/P IWMI+HTN+ HYPOTHYROIDISM, B/L PLEURAL ADHESIONS

SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, PDA]+ PERICARDIECTOMY DONE ON 25/04/2022.

C/o chest pain since 3 days.

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82min

BP-110/70mmhg

RR-21/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 50 years old female patient Mrs. D YELLAVVA presented to hospital with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+TVD+MYOCARDIAL ADHESIONS +S/P IWMI+HTN+ HYPOTHYROIDISM, B/L PLEURAL ADHESIONS, SURGERY –CORONARY ARTERY BYPASS

GRAFTING [SVG TO LAD, PDA]+PERICARDIECTOMY DONE ON 25/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, GLOBAL HYPOKINESIA, MILD MR/TR/PAH, MODERATE LV DYSFUNCTION, NO PE/CLOT/VEG

BMI is 21 kg/m2.

Sr. Creatinine report on 26.04.2022 1.1 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. TELMA 20 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. THYRONORM 100 MCG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. CARDARONE 100 MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.

8) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

10) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230278		**Name**	Mr. J MALLAIAH
Patient Identifier	ARHIP55508	**Age**	50Yr 0Mth 3Days
Sex	Male	**Date of Admission**	26-Apr-2022
Date of Discharge			
MLC No			
Address	theegalaguttapally,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%

R/F: HTN,DM

CORONARY ANGIOGRAM DONE ON 26/04/2022 – CAD-LM+SVD (LAD)

PRIMARY PTCA+DES TO LMCA, LAD WITH 3.5 X 19 MM METAFOR TO LAD, 4.0 X 13 MM METAFOR TO LMCA [LOT NO: MH11, S/N :CM19MH11016], [LOT NO: 5211889, S/N :05060127249091] DONE ON 26/04/2022.

C/o chest heaviness since 2 days

AT ADMISSION:

Afebrile

PR: 139/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 50 years old male patient Mr. J MALLAIAH came with c/o chest heaviness since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%, R/F: HTN,DM, CORONARY ANGIOGRAM DONE ON 26/04/2022 – CAD-LM+SVD (LAD), PRIMARY PTCA+DES TO LMCA, LAD WITH 3.5 X 19 MM METAFOR TO LAD, 4.0 X 13 MM METAFOR TO LMCA DONE ON 26/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

5) TAB. PANTOCID 40MG ONCE DAILY AT 8AM FOR 10 DAYS

6) TAB. ZORYL M1 ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

padmapanilws@gmail.com

ARH1.0001230229		**Name**	Mr. NARSAIAH TALLA		
	Patient Identifier	ARHIP55488		**Age**	54Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	24-Apr-2022
	Date of Discharge				
	MLC No				
	Address	2-22, LALITHAPOOR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU1 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI,

MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 26/04/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 20 MM METAFOR TO LAD [LOT NO: 24033502043A, S/N :22035203047] DONE ON 26/04/2022.

C/o chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old male patient Mr. NARSAIAH TALLA came with c/o chest pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 26/04/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 20 MM METAFOR TO LAD [LOT NO: 24033502043A, S/N :22035203047] DONE ON 26/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

5)TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001222014		**Name**	Mr. G MAHESH		
	Patient Identifier	ARHIP55495		**Age**	15Yr 7Mth 2Days
	Sex	Male		**Date of Admission**	25-Apr-2022
	Date of Discharge				
	MLC No				
	Address	DURSHED,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 5
	Primary Consultant	Dr. RAMCHANDER TORREM			

INFECTIVE ENDOCARDITIS
SEPTIC SHOCK
CKD ON MHD

C/o 1 episode tonic clonic seizures
Known case of CKD

AT ADMISSION:

Patient is irritable

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

Treated with

INJ MEROPENUM EDTA

INJ ISEPAMICIN

INJ PANTAPRAZOLE

INJ ZOFER

INJ LEVIPIL

INJ VANCOMYCIN

TAB ECOSPRIN

A 15 years old male patient Mr. G MAHESH came with c/o 1 episode of tonic clonic seizures and fever, Known case of CKD on regular dialysis. Patient has multi access failure and taking dialysis through left femoral catheter done. Initially we suspected catheter related sepsis, on evaluation 2D echo revealed infective endocarditis. Patient required ionotropic support, 4 cycles of renal replacement therapy done. MRI brain showed bilateral MCA infarcts. Neuro Physician Consultation Taken and advice followed. Patient referred to Higher Centre for CAPD .

DISCHARGE MEDICATION:

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1. TAB. ROXSAFE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. KETOCHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. A TO Z GOLD ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. DYTOR 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. TAB. MONTAIR AB TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
8. TAB. ND Q10 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS IN NEPHROLOGY OPD

ARH1.0001230272		**Name**	Mr. GANAPATHI DAGAM
Patient Identifier	ARHIP55505	**Age**	54Yr 0Mth 5Days
Sex	Male	**Date of Admission**	26-Apr-2022
Date of Discharge			
MLC No			
Address	REBBANA,KOMARAM BHEEM,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

S

CORONARY ARTERY DISEASE, NSTEMI, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 27/04/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR [LOT NO: MH32, S/N :CM13MH2047] DONE ON 27/04/2022

C/o chest pain a/w sweatings, SOB since 5 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54years old male patient Mr. GANAPATHI DAGAM came with c/o chest pain a/w sweatings, SOB since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 27/04/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR [LOT NO: MH32, S/N :CM13MH2047] DONE ON 27/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

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APH1.0001164249		**Name**	Mr. BODLA RAMULU
Patient Identifier	ARHIP55542	**Age**	74Yr 2Mth 25Days
Sex	Male	**Date of Admission**	29-Apr-2022
Date of Discharge			
MLC No			
Address	8-7-90,KOTHIRANPUR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
Primary Consultant	Dr. Vidya Sagar A--		

ACUTE DECOMPENSATED HEART FAILURE
ACUTE PULMONARY OEDEMA
DRUG NONCOMPLAINT
SEVERE LV SYSTOLIC DYSFUNCTION EF-27%
S/P DCMP WITH SEVERE LV DYSFUNCTION EF-30%,SR WITH LBBB
OPEN CHOLECYSTECTOMY 09/12/21

C/o shortness of breath grade 2 to 3 since 3 days associated with mild cough

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 120/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 74 years old male patient Mr. BODLA RAMULU came with c/o **shortness of breath grade 2 to 3 since 3 days associated with mild cough**. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, ACUTE PULMONARY OEDEMA, DRUG NONCOMPLAINT, SEVERE LV SYSTOLIC DYSFUNCTION EF-27%, S/P DCMP WITH SEVERE LV DYSFUNCTION EF-30%,SR WITH LBBB, OPEN CHOLECYSTECTOMY 09/12/21. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 20MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. LANOXIN 0.25 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE 5/7.
4. TAB: CARDIVAS 3.125MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. PLANEP T 25/10 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. VELOZ 20MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001230273		**Name**	Mr. LACHAIAH AMSHALA		
	Patient Identifier	ARHIP55504		**Age**	47Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	25-Apr-2022
	Date of Discharge				
	MLC No				
	Address	MALLAPUR,DHARMARAM,Other,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV DYSFUNCTION [EF-25%]

CORONARY ANGIOGRAM (28/04/2022) -CAD-SVD (LAD)

PLAN PTCA+STENT TO LAD LATER

C/o chest pain since 2-3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 47 years old male patient Mr. LACHAIAH AMSHALA came with c/o chest pain since 2-3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV DYSFUNCTION [EF-25%], CORONARY ANGIOGRAM (28/04/2022) -CAD-SVD (LAD), PLAN PTCA+STENT TO LAD LATER. Advised to get angioplasty done after fever has subsided, high risk explained to patient's family. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BETALOC 25MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. FRUSELAC DS ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

LIFE STYLE MODIFICATION

ARH1.0001230329		**Name**	Mrs. SHIVARATRI SWAROOPA		
	Patient Identifier	ARHIP55521		**Age**	42Yr 5Mth 3Days
	Sex	Female		**Date of Admission**	27-Apr-2022
	Date of Discharge				
	MLC No				
	Address	14-4-538, VITTAL NAGAR,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU13
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (30/04/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

R/F : HTN, DM

C/o chest pain since 20 days back

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient Mrs. SHIVARATRI SWAROOPA came with c/o chest pain since 20 days back. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (30/04/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB: RECLIMET ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001230337		**Name**	Mr. N SATHYANARAYANA		
	Patient Identifier	ARHIP55520		**Age**	60Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	27-Apr-2022
	Date of Discharge				
	MLC No				
	Address	N T R Colony,Mancherial,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (20/04/2022) -CAD-SVD [LAD]

MEDICAL MANAGEMENT FOR DIAGONAL [THIN VESSEL]

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 77/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old male patient Mr. N SATHYANARAYANA came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (20/04/2022) -CAD-SVD [LAD], MEDICAL MANAGEMENT FOR DIAGONAL [THIN VESSEL]. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. METOLAR XR ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230134		**Name**	Mr. RAJANNA D
Patient Identifier	ARHIP55464	**Age**	60Yr 0Mth 9Days
Sex	Male	**Date of Admission**	21-Apr-2022
Date of Discharge			
MLC No			
Address	Other,Other	**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 2
Primary Consultant	Dr. GOUTHAM ROY		

PERFORATED JEJUNAL DIVERTICULAR DISEASE
SURGERY: EXPLORATIVE LAPAROTOMY + JEJUNAL RESECTION, AND ANAESTHAMOSIS DONE ON 23.04.2022

C/o pain abdomen since 7 days
History of vomiting with mucous, contents food ,
Nausea, fever +

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 60yr old male patient Mr. RAJANNA D came with c/o pain abdomen since 7 days, history of vomiting with mucous, contents food , Nausea, fever +. All necessary investigations done and diagnosed as PERFORATED JEJUNAL DIVERTICULAR DISEASE, SURGERY: EXPLORATIVE LAPAROTOMY + JEJUNAL RESECTION, AND ANAESTHAMOSIS DONE ON 23.04.2022. Findings: Multiple diverticulum noted in the jejunum involving in the entire length, Few diverticulum were perforated. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 10 DAYS
5. SYP. LACTIHEP 15 ML ONCE DAILY AT 9 P.M.
6. SYP. SUCRAFIN 10 ML THRICE DAILY AT 8AM 2PM 8 P.M.
7. GLUTAVAULT –V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.0001090717		**Name**	Mr. MUKLA RAJENDRA PRASAD
Patient Identifier	ARHIP55552	**Age**	48Yr 7Mth 4Days
Sex	Male	**Date of Admission**	29-Apr-2022
Expired Date	30-Apr-2022		
MLC No			
Address	VALLAMPLLY,MEDIPALLY,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 12
Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Associate Consultant-Nephrologist,Consultant Nephrologist)--NEPHROLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type

PULMONARY EDEMA AND CKD (STAGE 5).

Patient brought to Emergency Room in gasping state for dialysis

AT ADMISSION:

Patient unconscious
PR: 113/min

BP: 60/? mmHg

CVS: S1S2

SPO2: 50% mechanical ventilator on 100% FIO2

A 48 years old male patient Mr. MUKLA RAJENDRA PRASAD brought to Emergency Room in gasping state from dialysis patient was undergoing dialysis when he suddenly developed shortness of breath followed by altered sensorium leading to gasping, Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols,continued for 5 cycles but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.19 am on 30/04/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO PULMONARY EDEMA AND CKD (STAGE 5).

ARH1.0001230088		**Name**	Mrs. LAXMI D
Patient Identifier	ARHIP55506	**Age**	60Yr 0Mth 14Days
Sex	Female	**Date of Admission**	26-Apr-2022
Date of Discharge			
MLC No			
Address	RAMAKRISHNAPUR,,Mancherial,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 4
Primary Consultant	Dr SOMASHEKAR K(MS,MCH		

CORONARY ARTERY DISEASE+TRIPLE VESSEL DISEASE+DIABETES MELLITUS+HYPERTENSION +S/P IWMI

SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 30/04/2022.

C/o retrosternal chest pain a/w sweating since 2 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 60 years old female patient Mrs. LAXMI presented to hospital with c/o retrosternal chest pain a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+TRIPLE VESSEL DISEASE+DIABETES MELLITUS+HYPERTENSION +S/P IWMI, SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 30/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD MR/TR/PAH, NORMAL LV SYSTOLIC FUNCTION. NO PE/CLOT/VEG

BMI is 20.3 kg/m2.

Sr. Creatinine report on 05.05.2022 1.7 mg/dl.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. MET-XL 25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001230023		**Name**	Mrs. SHAHEEN BEGUM		
	Patient Identifier	ARHIP55558		**Age**	40Yr 0Mth 16Days
	Sex	Female		**Date of Admission**	30-Apr-2022
	Date of Discharge	30-Apr-2022			
	MLC No				
	Address	,,Koratla,Telangana		**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME7
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

CORONARY ARTERY DISEASE- UNSTABLE ANGINA.
R/F:DIABETES MELLITUS.
CORONARY ANGIOGRAM DONE ON 30/04/2022.
IMP:NORMAL CORONARIES(MYOCARDIAL BRIDGING PRESENT)
PLAN:MEDICAL MANAGEMENT

C/o vomiting 5-6 episodes since 2-3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 80/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old female patient Mrs. SHAHEEN BEGUM came with c/o vomiting 5-6 episodes since 2-3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- UNSTABLE ANGINA.
R/F:DIABETES MELLITUS, CORONARY ANGIOGRAM DONE ON 30/04/2022, NORMAL CORONARIES (MYOCARDIAL BRIDGING PRESENT), PLAN:MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSUVAS 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. CONTINUE DIABETES MEDICATION

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229598		**Name**	Ms. MD SALMA	
Patient Identifier	ARHIP55559		**Age**	45Yr 1Mth 0Days
Sex	Female		**Date of Admission**	30-Apr-2022
Date of Discharge	03-May-2022			
MLC No				
Address	SAIDAPUR,HUZURABAD,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
CONTRAST INDUCED NEPHROPATHY METABOLIC ACIDOSIS, CAD ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION,SR,NO,TLT, GLOBAL HYPOKALEMIA OF LV,SEVERE LV DYSFUNCTION EF-25% S/P CAG+PTCA+DES TO LAD DONE ON 6/4/22. R/F;HYPERTENSION DIABETIC MELLITUS RECENT CKD	

C/o shortness of breath grade-4 since 25 days associated with cough and sputum

AT ADMISSION:

Afebrile

PR: 98/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 25/min

SPO2: 97%

P/A: Soft

A 45 years old female patient Ms. MD SALMA came with c/o shortness of breath grade-4 since 25 days associated with cough and sputum. All necessary investigations were done and diagnosed as CONTRAST INDUCED NEPHROPATHY METABOLIC ACIDOSIS, CAD ACUTE ANTERIOR WALL MYOCARDIAL, INFARCTION,SR,NO,TLT, GLOBAL HYPOKALEMIA OF LV,SEVERE LV DYSFUNCTION EF-25%, S/P CAG+PTCA+DES TO LAD DONE ON 6/4/22, R/F;HYPERTENSION, DIABETIC MELLITUS, RECENT CKD. Nephrologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ROSEDAY 20MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. CONCOR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. ALCYSTA ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. MONTAIR AB ONCE DAILY AT 8PM TO CONTINUE.

7) TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

8) SYP. ASCORIL-LS 10 ml TWICE DAILY AT 8AM AND 8PM

9) TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH RP-II, FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230387	**ARHIP55535**	Mr. G VENU KUMAR | Male | 35Yr 0Mth 6Days

CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY
LEFT HEMIPARESIS
T2DM
? SEIZURES

C/o slurring of speech, sudden in onset of left sided weakness

AT ADMISSION:

Afebrile

PR: 84/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 35 years old male patient Mr. G VENU KUMAR came with c/o slurring of speech, sudden in onset of left sided weakness . All necessary investigations were done and diagnosed as CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY, LEFT HEMIPARESIS, T2DM, ? SEIZURES. Managed conservatively. General physician consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB: ZORYL MV2 TWICE DAILY AT 8AM 8PM FOR 10DAYS.
2. TAB: DAPAGLYN 10MG ONCE DAILY AT 8AM FOR 10DAYS.
3. TAB: ECOSPRIN 150MG ONCE DAILY AT 8AM TO CONTINUE

4. TAB: ATORVASTATIN 40MG ONCE DAILY AT 8AM TO CONTINUE

5. TAB: TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE

6. TAB: LEVIPIL 500MG ONCE DAILY AT 8AM TO CONTINUE

7. TAB: STAMLO 2.5 MG ONCE DAILY AT 8AM TO CONTINUE

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001230069

Name	Mrs. RUKSANA BEGUM		
Patient Identifier	ARHIP55475	**Age**	50Yr 0Mth 11Days
Sex	Female	**Date of Admission**	23-Apr-2022
Expired Date	01-May-2022		
MLC No			
Address	4-1-10 VANI NAGAR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CT POST, Bed no:CT 3
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Consultants**	
Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE,DOUBLE VESSEL DISEASE,SEVERE LV DYSFUNCTION,HYPERTENTION,DIABETES MELLITUS, S/P CORONARY ARTERY BYPASS GRAFTING	

C/o chest pain since 3 days

AT ADMISSION:

PR: 89/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old female patient Mrs. RUKSANA BEGUM came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE,DOUBLE VESSEL DISEASE,SEVERE LV DYSFUNCTION,HYPERTENTION,DIABETES MELLITUS, S/P CORONARY ARTERY BYPASS GRAFTING. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.00 AM on 01/05/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO LOW CARDIAC OUTPUT FAILURE -S/P CABG

ARH1.0001230453

Name	Mr. BAPU B		
Patient Identifier	ARHIP55560	**Age**	62Yr 0Mth 4Days
Sex	Male	**Date of Admission**	30-Apr-2022
Date of Discharge	03-May-2022		
MLC No			
Address	REBBENA, ASIFABAD. 8019673105,Telangana	**Ward/Bed No**	CICU , CICU , Bed no:CICU1 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

⊟ Diagnosis

Diagnosis

Disease	Disease Type

CAD NON ST ELEVATION MYOCARDIAL INFARCTION,SR,NO TLT,MILD MR,MILD LV DYSFUNCTION,EF-46%
CORONARY ANGIOGRAM DONE ON 30/04/22
PRIMARY PTCA+DES TO LAD(XIENCE XPEDITION 3X18MM) DONE ON 30/04/2022.
R/F;HYPERTENSION
DENOVA DIABETIC MILLITUS
ALCOHOL.

C/o SOB on exertion, chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. BAPU B came with c/o SOB on exertion, chest pain since 3 days. All necessary investigations were done and diagnosed as CAD NON ST ELEVATION MYOCARDIAL INFARCTION,SR,NO TLT,MILD MR,MILD LV DYSFUNCTION,EF-46%, CORONARY ANGIOGRAM DONE ON 30/04/22, PRIMARY PTCA+DES TO LAD(XIENCE XPEDITION 3X18MM) DONE ON 30/04/2022, R/F;HYPERTENSION, DENOVA DIABETIC MILLITUS, ALCOHOL. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. TAZLOC BETA 50MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. TAZLOC H 40MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

7) LIFE STYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230511		**Name**	Mrs. MALYALA SAROJA		
	Patient Identifier	ARHIP55578		**Age**	50Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	03-May-2022
	Date of Discharge				
	MLC No				
	Address	H NO-26-380/1,HAMALIWADA,Mancherial,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

DCMP, MODERATE MR, SR, LBBB,

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o SOB on exertion, dry cough since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 50 years old female patient Mrs. MALYALA SAROJA came with c/o SOB on exertion, dry cough since 7 days. All necessary investigations were done and diagnosed as DCMP, MODERATE MR, SR, LBBB, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
5. TAB. DYTOR PLUS 10MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230446		**Name**	Mr. PULLUTI NARSAIAH
Patient Identifier	ARHIP55562	**Age**	54Yr 3Mth 5Days
Sex	Male	**Date of Admission**	30-Apr-2022
Date of Discharge			
MLC No			
Address	6-3-12, DURGAMMAGADDHA,KARIMNAGAR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: HYPERTENSION

CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 24 MM METAFOR DONE ON 02/05/2022

C/o left sided chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54years old male patient Mr. PULLUTI NARSAIAH came with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 24 MM METAFOR [LOT NO: MH30, S/N :CM24MH30071] DONE ON 02/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. EPTOIN 100 MG 2 TAB ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

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ARH1.0001230345		**Name**	Mr. K MADHAIAH		
	Patient Identifier	ARHIP55531		**Age**	53Yr 0Mth 8Days
	Sex	Male		**Date of Admission**	28-Apr-2022
	Date of Discharge				
	MLC No				
	Address	SATHARAM KORUTLA,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU13
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

R/F : HYPERTENSION, ALCOHOL, BRONCHIAL ASTHMA

CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o severe SOB grade-IV since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 53 years old male patient Mr. K MADHAIAH came with c/o severe SOB grade-IV since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], R/F : HYPERTENSION, ALCOHOL, BRONCHIAL ASTHMA, CORONARY ANGIOGRAM (04/05/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN GOLD 10MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CARDIVAS 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. FRUSELAC ONCE **IN A DAY AT 8 AM** TO CONTINUE.
4. TAB. LOSAR 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. VOBOSE 0.3 MG ONCE DAILY AT 2PM BEFORE LUNCH TO CONTINUE.
6. CAP. ABFLO 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230465		**Name**	Mr. RAMAGIRI NAGESH		
	Patient Identifier	ARHIP55569		**Age**	33Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	02-May-2022
	Date of Discharge				
	MLC No				
	Address	3-69,peddampet,upparlakesaram,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LCX)

PTCA+DES TO LCX WITH 2.75 X 19 MM METAFOR DONE ON 02/05/2022

C/o chest pain since 1 day a/w SOB, palpitations

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 33years old male patient Mr. RAMAGIRI NAGESH came with c/o chest pain since 1 day a/w SOB, palpitations. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LCX), PTCA+DES TO LCX WITH 2.75 X 19 MM METAFOR [LOT NO: MG78, S/N :CM19MG78015] DONE ON 02/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 8PM TO CONTINUE.

3) TAB. ROSUVAS 40MG ONCE DAILY AT 8AM TO CONTINUE.

4) SYP. POTKLOR 15 ml THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

LIFE STYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230427		**Name**	Mrs. LAXMI B		
	Patient Identifier	ARHIP55557		**Age**	55Yr 0Mth 7Days
	Sex	Female		**Date of Admission**	30-Apr-2022
	Date of Discharge	01-May-2022			
	MLC No				
	Address	5-2/A 7 EKLSAPUR,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU12
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CORONARY ARTERY DISEASE-ACUTE INFERIOR WALL MYOCARDIAL INFARCTION NO TLT, SR.SEVERE LV SYSTOLIC DYSFUNCTION EF:30%.

C/o chest pain a/w SOB since 4 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 100/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. LAXMI B came with c/o chest pain a/w SOB since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230325

Name	Mrs. VIJAYA DURISETTI		
Patient Identifier	ARHIP55513	**Age**	54Yr 0Mth 9Days
Sex	Female	**Date of Admission**	27-Apr-2022
Date of Discharge	01-May-2022		
MLC No			
Address	2-74 BHEEMARAM,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CORONARY ARTERT DISEASE-ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION WITH APICAL VENTRICULAR SEPTAL RUPTURE,MILD MR,SR.
SEVERE LV SYSTOLIC DYSFUNCTION

C/o chest pain sudden onset, pain radiating to left arm a/w SOB

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 54 years old female patient Mrs. VIJAYA DURISETTI came with c/o chest pain sudden onset, pain radiating to left arm a/w SOB. All necessary investigations were done and diagnosed as CORONARY ARTERT DISEASE-ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION WITH APICAL VENTRICULAR SEPTAL RUPTURE,MILD MR,SR, SEVERE LV SYSTOLIC DYSFUNCTION. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230429		**Name**	Mr. R MALLAIAH		
	Patient Identifier	ARHIP55555		**Age**	62Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	30-Apr-2022
	Date of Discharge	03-May-2022			
	MLC No				
	Address	BHUPATHPUR,Karimnagar,Telangana		**Ward/Bed No**	First Floor,

CICU , Bed no:CICU 4

Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

CAD- ANTERIOR WALL MYOCARDIAL INFARCTION SR,NO TLT,MILD LV SYSTOLIC DYSFUNCTION, CORONARY ANGIOGRAM DONE ON 30/04/22.
PRIMARY PTCA+DES TO LCX (3V ASTRA 2.75X16MM)
PTCA+DES TO LAD(METAFOR 3X16MM DONE ON 30/04/22.
R/F DIABETIC MELLITUS

C/o chest pain a/w vomiting since 2 days

AT ADMISSION:

Afebrile

PR: 84/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. R MALLAIAH came with c/o chest pain a/w vomiting since 2 days. All necessary investigations were done and diagnosed as CAD- ANTERIOR WALL MYOCARDIAL INFARCTION SR,NO TLT,MILD LV SYSTOLIC DYSFUNCTION, CORONARY ANGIOGRAM DONE ON 30/04/22, PRIMARY PTCA+DES TO LCX (3V ASTRA 2.75X16MM), PTCA+DES TO LAD(METAFOR 3X16MM DONE ON 30/04/22.

R/F DIABETIC MELLITUS. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

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ARH1.0001230602		**Name**	Mrs. NOOKALA MALLU		
	Patient Identifier	ARHIP55605		**Age**	65Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	06-May-2022
	Date of Discharge				
	MLC No				
	Address	chennur,Mancherial,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ICMP, MODERATE MR, SR,

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

R/F HTN

CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-TVD (LAD, LCX, RCA)

PLAN CABG.

C/o Retrosternal chest pain, radiating to the back since 2 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 65 years old female patient Mrs. NOOKALA MALLU came with c/o retrosternal chest pain, radiating to the back since 2 days. All necessary investigations were done and diagnosed as ICMP, MODERATE MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F HTN, CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-TVD (LAD, LCX, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BISOMAX L 2.5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. ANGISPAN TR 2.5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. RABIFER 20 MG ONCE DAILY AT 8AM FOR 7 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001230492		**Name**	Mr. B SRINIVAS
Patient Identifier	ARHIP55570	**Age**	55Yr 0Mth 4Days
Sex	Male	**Date of Admission**	02-May-2022
Date of Discharge			
MLC No			
Address	Godavarikhani, peddapally,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, AWMI, NO TLT, KILLIPS CLASS-4,

SEVERE LV DYSFUNCTION, EF-30%

R/F: HYPERTENSION

CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 2.5 X 12 MM 3 V ASTRA DONE ON 02/05/2022
CARDIOGENIC SHOCK RECOVERED

C/o chest pain since 1 day a/w mild cough

AT ADMISSION:

Afebrile

PR: 112/min

BP: 100/50mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 55years old male patient Mr. B SRINIVAS came with c/o chest pain since 1 day a/w mild cough. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, NO TLT, KILLIPS CLASS-4, SEVERE LV DYSFUNCTION, EF-30%, R/F: HYPERTENSION , CORONARY ANGIOGRAM DONE ON 02/05/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 2.5 X 12 MM 3 V ASTRA [LOT NO: 240335032043A, S/N :22035323036] DONE ON 02/05/2022, CARDIOGENIC SHOCK RECOVERED. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

Sujatha pediclse screw sunbrath

Raju pcnl sures

ARH1.0001230600		**Name**	Mr. M HARI SINGH		
	Patient Identifier	ARHIP55603		**Age**	46Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	05-May-2022
	Date of Discharge				
	MLC No				
	Address	CHINTHAKUNTA SIRPUR KHAGAZNAGAR KOMURAM BHEEM,Adilabad(Adilabad),Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, TRIVIAL MR, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

TLT WITH TENECTOPLUS DONE ON 05/05/2022

R/F: HTN

CORONARY ANGIOGRAM (06/05/2022) -CAD-SVD (RCA)

ADV: PTCA+DES TO RCA

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 46 years old male patient Mr. M HARI SINGH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, TRIVIAL MR, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], R/F: HTN, CORONARY ANGIOGRAM (06/05/2022) -CAD-SVD (RCA), ADV: PTCA+DES TO RCA. PTCA abandoned as balloon could not be crossed over the lesion and referred to higher center for further management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

ARH1.0001230530		**Name**	Mr. R VISHNU		
	Patient Identifier	ARHIP55586		**Age**	36Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	04-May-2022
	Date of Discharge				
	MLC No				
	Address	SIRICILLA,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

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CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 04/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022
R/F: DENOVO DIABETES

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 36 years old male patient Mr. R. VISHNU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 04/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.

LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230522		**Name**	Mr. SHAIK MOHINODDIN		
	Patient Identifier	ARHIP55585		**Age**	42Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	04-May-2022
	Date of Discharge				
	MLC No				
	Address	KORUTLA,Karimnagar,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, AWMI, SR, NO TLT,

MODERATE LV DYSFUNCTION, EF-35%

MILD TR/PAH/MR

CORONARY ANGIOGRAM DONE ON 04/05/2022 – CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 37 MM METAFOR DONE ON 04/05/2022
R/F: T2DM

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient Mr. SHAIK MOHINODDIN came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, SR, NO TLT, MODERATE LV DYSFUNCTION, EF-35%, MILD TR/PAH/MR, CORONARY ANGIOGRAM DONE ON 04/05/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 37 MM METAFOR [LOT NO: MH22, S/N :CM37MH22001] DONE ON 04/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. BETALOC 25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. GLYCOMET SR 500MG ONCE DAILY AT AFTER BREAKFAST TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

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ARH1.0001081771		**Name**	Mr. K MALLAIAH		
	Patient Identifier	ARHIP55607		**Age**	52Yr 11Mth 15Days
	Sex	Male		**Date of Admission**	06-May-2022
	Date of Discharge				
	MLC No				
	Address	3-6-514,SUBASH NAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 1
	Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant			

GALLSTONE DISEASE
SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022

C/o pain abdomen since 5 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 52 yr old male patient K. MALLAIAH came with c/o pain abdomen since 5 days. All necessary investigations done and diagnosed as GALLSTONE DISEASE, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022. Findings: Well distended gallbladder with calot's. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS

Review after 7 days in General Surgery OPD.

ARH1.0001230597		**Name**	Mr. CHELIMALLA MONDAIAH
Patient Identifier	ARHIP55598	**Age**	60Yr 0Mth 2Days
Sex	Male	**Date of Admission**	05-May-2022
Date of Discharge			
MLC No			
Address	INDIRANAGAR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 9
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-DVD (RAMUS, LCX)

PTCA+DES TO RAMUS WITH 3.0 X 16 MM METAFOR, LCX WITH 3.5 X 13 MM METAFOR DONE ON 05/05/2022
R/F: T2DM

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 60 years old male patient Mr. CHELIMALLA MONDAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-DVD (RAMUS, LCX), PTCA+DES TO RAMUS WITH 3.0 X 16 MM METAFOR, LCX WITH 3.5 X 13 MM METAFOR DONE ON 05/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. RECLIDE XR 60 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230587		**Name**	Mr. KARNALA GANGADAR
Patient Identifier	ARHIP55597	**Age**	24Yr 0Mth 2Days
Sex	Male	**Date of Admission**	05-May-2022
Date of Discharge			
MLC No			
Address	ITIKYALA,JAGITYAL,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA CC DONE ON 05/05/2022
R/F: ALCOHOLIC

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 107/min

BP: 100/50mmHg

RS: BAE+

CVS: S1S2+

RR: 22/min

SPO2: 99%

P/A: Soft

A 24 years old male patient Mr. KARNALA GANGADAR came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA CC DONE ON 05/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. NOVASTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230521		**Name**	Mr. MOHD GOUSIDDUN
Patient Identifier	ARHIP55584	**Age**	83Yr 0Mth 4Days
Sex	Male	**Date of Admission**	04-May-2022
Date of Discharge			
MLC No			
Address	6-2-39, Bendapelly,Karimnagar,Telangana	**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI,

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-TVD (LAD, LCX, RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 40 MM METAFOR DONE ON 04/05/2022 (CABG LATER)
R/F: HTN

C/o chest pain a/w SOB since 4 days

AT ADMISSION:

Afebrile

PR: 78/min

BP: 100/50mmHg

RS: BAE+

CVS: S1S2+

RR: 22/min

SPO2: 99%

P/A: Soft

A 83 years old male patient Mr. MOHD GOUSIDDUN came with c/o chest pain a/w SOB since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 05/05/2022 – CAD-TVD (LAD, LCX, RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 40 MM METAFOR DONE ON 04/05/2022, (CABG LATER). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.

5) TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. DYTOR 10MG ONCE DAILY AT 2PM TO CONTINUE.

7) TAB. MUCINAC 600 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229014		**Name**	Mr. B ANIL		
	Patient Identifier	ARHIP55630		**Age**	22Yr 1Mth 19Days
	Sex	Male		**Date of Admission**	07-May-2022
	Date of Discharge				
	MLC No				
	Address	KOHEDA,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 1
	Primary Consultant	Dr. Iftekarali (MS (Orthopaedics			

K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT

SURGERY : K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT DONE ON 07/05/2022

Patient came for K-wire removal

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-98/min
BP-120/80mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 22 years old male patient Mr. ANIL came for k-wire removal . All necessary investigations were done and diagnosed as K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT, SURGERY : K-WIRE REMOVAL 3RD AND 4TH TOE RIGHT DONE ON 07/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
4. TAB. AFFICAL PLUS ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

55629 RADHAVVA 70

K-WIRE REMOVAL RIGHT AND LEFT WRIST

SURGERY : K-WIRE REMOVAL RIGHT AND LEFT WRIST DONE ON 07/05/2022

Patient came for K-wire removal

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-99/min
BP-120/80mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 70 years old female patient RADHAVVA came for k-wire removal . All necessary investigations were done and diagnosed as K-WIRE REMOVAL RIGHT AND LEFT WRIST, SURGERY : K-WIRE REMOVAL RIGHT AND LEFT WRIST DONE ON 07/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:
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1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
4. TAB. AFFICAL PLUS ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001063071		**Name**	Mr. NARAYANA GARREPALLI
Patient Identifier	ARHIP55563	**Age**	55Yr 8Mth 29Days
Sex	Male	**Date of Admission**	30-Apr-2022
Date of Discharge			
MLC No			
Address	3-149/1,SUNDILLA,KAMANPUR,Karimnagar,Andhra Pradesh	**Ward/Bed No**	First Floor, CT POST, Bed no:CT 5
Primary Consultant	Dr SOMASHEKAR K(MS,		

CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION + DM+HTN+S/P IRS OF RCA+AWMI

SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 05/05/2022.

C/o left sided chest pain, shortness of breath on exertion since 3 days

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old male patient Mr. NARAYANA GARREPALLI came with c/o left sided chest pain, shortness of breath on exertion since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION + DM+HTN+S/P IRS OF RCA+AWMI, SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 05/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, TRIVIAL MR, SEVERE LV SYSTOLIC DYSFUNCTION, GRADE-I DIASTOLIC DYSFUNCTION. NO PE/CLOT/VEG, EF-30%

BMI is 18.6 kg/m2.

Sr. Creatinine report on 03/02/2022 0.8 mg/dl.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

6) TAB. MET XL 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

7) TAB. CARDARONE 200 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

8) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

9) TAB. ROXSAFE CV 125+100 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

10) TAB. DIXIN 0.25MG ONCE DAILY AT 8AM TO CONTINUE.

11) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

12) TAB. GEMER 1 MG ONCE DAILY AT 7AM BBF TO CONTINUE.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001230601		**Name**	Mrs. ASHAMMA MOTHE		
	Patient Identifier	ARHIP55604		**Age**	70Yr 0Mth 4Days
	Sex	Female		**Date of Admission**	05-May-2022
	Date of Discharge				
	MLC No				
	Address	3-47/2 REGUNTA,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, IWMI

MILD LV DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-SVD (RCA)

PTCA+DES TO RCA (TWO STENTS) WITH 3.5 X 44 MM METAFOR TO RCA, 4.0 X 13 MM METAFOR TO RCA DONE ON 06/05/2022

C/o sudden onset of chest pain a/w SOB 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 70years old female patient Mrs. ASHAMMA MOTHE came with c/o sudden onset of chest pain a/w SOB 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, MILD LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-SVD (RCA), PTCA+DES TO RCA (TWO STENTS) WITH 3.5 X 44 MM METAFOR TO RCA, 4.0 X 13 MM METAFOR TO RCA [LOT NO: MH20 , S/N :CM44MH20036 & LOT NO: MH36 , S/N :CL13MH36020] DONE ON 06/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

.0001230496		**Name**	Mrs. PADMA BHUMADI		
	Patient Identifier	ARHIP55577		**Age**	53Yr 0Mth 7Days
	Sex	Female		**Date of Admission**	02-May-2022
	Date of Discharge				
	MLC No				
	Address	MALLANNAPET,Nirmal,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 3
	Primary Consultant	Dr. SURESH GOUD			

RIGHT RENAL CALCULUS
RIGHT PCNL+DJ STENTING DONE ON 05.05.2022

C/o Right loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 53 yrs old female patient Mrs. PADMA BHUMADI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PCNL+DJ STENTING DONE ON 05.05.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

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1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP: CREMAFFIN 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001229468		**Name**	Mr. S RAMAKRISHNA
Patient Identifier	ARHIP55609	**Age**	46Yr 1Mth 9Days
Sex	Male	**Date of Admission**	06-May-2022
Date of Discharge			
MLC No			
Address	DURSHED,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:105 B
Primary Consultant	Dr. GOUTHAM ROY (		

SCROTAL WALL WOUND SECONDARY TO S/P I & D
SURGERY: SCROTAL WALL SECONDARY SUTURING DONE ON 07.05.2022

C/o non healing of left scrotal wound came for suturing

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 46yr old male patient Mr. RAMAKRISHNA came with c/o non healing of left scrotal wound came for suturing . All necessary investigations done and diagnosed as SCROTAL WALL WOUND SECONDARY TO S/P I & D, SURGERY: SCROTAL WALL SECONDARY SUTURING DONE ON 07.05.2022. Findings: Healing ulcer with granulation tissues. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE CV 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: CIPLOX 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 10 DAYS.
4. TAB: ROTAVAULT THRICE DAILY AT 8AM, 2PM AND 8PM FOR 7 DAYS.
5. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
6. TAB: ND Q10 ONCE DAILY AT 2PM FOR 10 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001230704		**Name**	Mr. RENDLA KAMALAKAR
Patient Identifier	ARHIP55652	**Age**	34Yr 0Mth 1Days
Sex	Male	**Date of Admission**	09-May-2022
Date of Discharge			
MLC No			
Address	THADAGONDA,Sircilla,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 5
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

MULTIPLE HAEMORRHAGIC CONTUSIONS
ACUTE SAH
SDH
FRACTURE RIGHT LATERAL AND MEDIAL PTERYGOID PLATE
ASPIRATION

Alleged history of slip and fall from 2 wheeler on 08/05/2022 at 2 p.m.
 Ear injury with bleed present

PHYSICAL EXAMINATION:

ON ADMISSION

Patient connected to ventilator

PR-130/min

BP-80/50mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-84%

GCS: E1,V1,M1

A 34 yrs old male patient Mr. RENDLA KAMALAKAR came with alleged history of slip and fall from 2 wheeler on 08/05/2022 at 2 p.m, Ear injury with bleed present. All necessary investigations done and diagnosed as MULTIPLE HAEMORRHAGIC CONTUSIONS, ACUTE SAH, SDH, FRACTURE RIGHT LATERAL AND MEDIAL PTERYGOID PLATE, ASPIRATION. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001082508		**Name**	Mr. BAYYANI MALLAIAH		
	Patient Identifier	ARHIP55538		**Age**	65Yr 11Mth 9Days
	Sex	Male		**Date of Admission**	28-Apr-2022
	Date of Discharge				
	MLC No				
	Address	MADHAPUR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY
POST PTCA
AKI

C/o Weakness of right upper limb and lower limb, slurring of speech since 1 day
k/c/o HTN, T2DM, CAD
S/P PTCA

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 65 years old male patient Mr. BAYYANI MALLAIAH came with c/o weakness of right upper limb and lower limb, slurring of speech since 1 day. k/c/o HTN, T2DM, CAD. All necessary investigations were done and diagnosed as CVA-ACUTE INFARCT IN RIGHT MCA TERRITORY, POST PTCA, AKI. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230652		**Name**	Mrs. BHARATHI GAJJELLI		
	Patient Identifier	ARHIP55627		**Age**	62Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	07-May-2022
	Date of Discharge				
	MLC No				
	Address	3-8-22, SHANTHINAGAR,,Sircilla,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 5
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL			

ACUTE HEART FAILURE
COMMUNITY ACQUIRED PNEUMONIA
DENOVO DIABETES MELLITUS
CAD WITH SEVERE LV DYSFUNCTION

Patient presented with complaints of fever cough since 8 days, shortness of breath grade-IV since 1 day

AT ADMISSION:
Patient drowsy, gasping
PR: 116/min
BP: 180/100mmHg
RS: BAE+, crepts+
CVS: S1S2
RR: 34/min
SPO2: 70% on room air
P/A: Soft

A 62-year-old female patient Mrs. BHARATHI GAJJELLI presented with the above-mentioned complaints. Patient was drowsy and immediately intubated and connected to mechanical ventilator. Cardiology consultation was taken and advice followed. Patient was hypotensive and treated with INJ. NORADRENALINE, INJ. LASIX, INJ HUMAN ACTRAPID INSULIN AND WITH ANTIBIOTICS, ANTI-PLATELETS AND STATINS. On day 2 patient got extubated and required 4 L of O2 support . Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

55656

ARH1.0001229999		**Name**	Mrs. VAJRA KOPPULA		
	Patient Identifier	ARHIP55656		**Age**	53Yr 0Mth 21Days
	Sex	Female		**Date of Admission**	09-May-2022
	Date of Discharge				
	MLC No				
	Address	vemulawada,Sircilla,Telangana		**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

PREOPERATIVE CARDIAC EVALUATION WITH ECG CHANGES
NORMAL LV SYSTOLIC FUNCTION
R/F: HYPERTENSION, DIABETES MELLITUS
CORONARY ANGIOGRAM (09/05/2022) - PROXIMAL LAD MILD DISEASE
ANOMALOUS RCA ORIGIN FOR LEFT SINUS
ADV: MEDICAL MANAGEMENT

Patient came for preoperative cardiac evaluation with ECG changes

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old female patient Mrs. VAJRA KOPPULA patient came for preoperative cardiac evaluation with ECG changes. All necessary investigations were done and diagnosed as PREOPERATIVE CARDIAC EVALUATION WITH ECG CHANGES, NORMAL LV SYSTOLIC FUNCTION, R/F: HYPERTENSION, DIABETES MELLITUS
CORONARY ANGIOGRAM (09/05/2022) - PROXIMAL LAD MILD DISEASE ANOMALOUS RCA ORIGIN FOR LEFT SINUS, ADV: MEDICAL MANAGEMENT. Patient can undergo non-cardiac surgery under mild risk. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. TAZLOC 80 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. AZITOR 20 MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. OXRAMET XR 10 /500 ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER SURGERY TO CARDIAC OPD

ARH1.0001230528		**Name**	Mr. MALLAIAH BOLLAM		
	Patient Identifier	ARHIP55588		**Age**	66Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	04-May-2022
	Date of Discharge				
	MLC No				
	Address	ANANTHARAM,Sircilla,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:MGW 24
	Primary Consultant	Dr. Vidya Sagar A--			

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

MILD LV DYSFUNCTION [EF-45%]

R/F : T2DM

CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 19 MM METAFOR TO PROXIMAL RCA, 3.0 X 24 MM 3V ASTRA TO MID RCA DONE ON 06/05/2022

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 66years old male patient Mr. MALLAIAH came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MILD LV DYSFUNCTION [EF-45%], R/F : T2DM , CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 19 MM METAFOR TO PROXIMAL RCA, 3.0 X 24 MM 3V ASTRA TO MID RCA DONE ON 06/05/2022 . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. GLYCOMET GP 1 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

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ARH1.0001230481		**Name**	Mrs. YELLAMMA PARUNANDI		
	Patient Identifier	ARHIP55571		**Age**	75Yr 0Mth 7Days
	Sex	Female		**Date of Admission**	02-May-2022
	Date of Discharge				
	MLC No				
	Address	KOTHAPALLY,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 11
	Primary Consultant	Dr. RAMCHANDER TORREM			

CKD STAGE-V

DM AND HTN

C/o swelling of feet, decreased appetite

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old female patient Mrs. YELLAMMA PARUNANDI came with c/o swelling of feet, decreased appetite. All necessary investigations were done and diagnosed as CKD STAGE-V, DM AND HTN. 2 PCV transfusions given, 2 sessions of haemodialysis done . Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. CEFARAX-CV TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. KETOCHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. CINOD 10 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM FOR 10 DAYS.
7. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
8. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001230611		**Name**	Mrs. J VIJAYA LAXMI
Patient Identifier	ARHIP55608	**Age**	68Yr 0Mth 3Days
Sex	Female	**Date of Admission**	06-May-2022
Date of Discharge			
MLC No			
Address	MUKARAMPURA,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-DVD (LAD, RCA)

PTCA+DES TO LAD, RCA (TWO STENTS) WITH 2.75 X 18 MM PRANOVA TO LAD, 3.5 X 28 MM 3V ASTRA TO RCA DONE ON 06/05/2022

C/o chest pain a/w palpitations since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 68 years old female patient Mrs. J VIJAYA LAXMI came with c/o chest pain a/w palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV SYSTOLIC FUNCTION [EF-60%], CORONARY ANGIOGRAM DONE ON 06/05/2022 – CAD-DVD (LAD, RCA), PTCA+DES TO LAD, RCA (TWO STENTS) WITH 2.75 X 18 MM PRANOVA TO LAD, 3.5 X 28 MM 3V ASTRA TO RCA DONE ON 06/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. TAZLOC 40MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001226633		**Name**	Mr. SHANKARAIAH KOTHAPALLY		
	Patient Identifier	ARHIP55576		**Age**	49Yr 3Mth 23Days
	Sex	Male		**Date of Admission**	02-May-2022
	Date of Discharge				
	MLC No				
	Address	H.NO: 2-72,VENKATARAOPET,LUXXETIPET,MANCHIRAIL,Other,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 14
	Primary Consultant	DR. SUBRAT KUMAR SOREN --NEUROSURGERY			

RIGHT SIDE CALVARIAL DEFECT
SURGERY: RIGHT AUTOLOGOUS CRANIOPLASTY DONE ON 05/03/2022

Patient came for autologous cranioplasty

K/c/o CVA, IC Bleed and HTN

AT ADMISSION:

Patient c/c/c
PR: 88/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 49 years old male patient Mr. SHANKARAIAH KOTHAPALLY came for autologous cranioplasty, K/c/o CVA, IC Bleed and HTN. All necessary investigations were done and diagnosed as RIGHT SIDE CALVARIAL DEFECT, SURGERY: RIGHT AUTOLOGOUS CRANIOPLASTY DONE ON 05/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS

2. TAB. TELMA 40 MG ONCE DAILY AT 8AM FOR 11 DAYS

3. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.

4. TAB. AUGMENTIN DUO TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS

5. TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001230507		**Name**	Mr. R PARVATHI		
	Patient Identifier	ARHIP55575		**Age**	70Yr 0Mth 7Days
	Sex	Male		**Date of Admission**	02-May-2022
	Date of Discharge				
	MLC No				
	Address	karimnagar,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:111 B
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

LEFT DORSAL MEDULLARY CEREBELLAR INFARCT

C/o Giddiness, headache, nausea and vomiting since 2 days

AT ADMISSION:

PR: 92/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 70 years old female patient R PARVATHI came with c/o giddiness, headache, nausea and vomiting since 2 days. All necessary investigations were done and diagnosed as LEFT DORSAL MEDULLARY CEREBELLAR INFARCT . Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE

2) TAB. STORVAS 40 MG ONCE DAILY AT 2PM TO CONTINUE

3) TAB. ZORYL-M1 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE

4) TAB. DAPARYL 10 MG ONCE DAILY AT 2PM TO CONTINUE

5) TAB. SARTEL-H ONCE DAILY AT 2PM TO CONTINUE

6) TAB. ZEVERT 20 MG **TWICE IN A DAY AT 8 AM 8 PM**

7) TAB. NEUROCETAM ONCE DAILY AT 2PM TO CONTINUE

8) TAB. ZOFER 4 MG **THRICE IN A DAY AT 8 AM 2 PM 8 PM** TO CONTINUE

9) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001230475		**Name**	Mrs. VEERABATHINI THARA		
	Patient Identifier	ARHIP55654		**Age**	45Yr 0Mth 7Days
	Sex	Female		**Date of Admission**	09-May-2022
	Date of Discharge				
	MLC No				
	Address	J.P NAGAR,Sircilla,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 3
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH			

AV MALFORMATION IN RIGHT WRIST
AV MALFORMATION EXCISION IN RIGHT WRIST ANTERIORLY DONE ON 09/05/2022

Complaint of swelling and pain in right wrist since 15 days

AT ADMISSION:

Patient c/c/c
PR: 82/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 45 years old female patient Mrs. VEERABATHINI THARA came with complaint of swelling and pain in right wrist since 15 days. All necessary investigations were done and diagnosed as AV MALFORMATION IN RIGHT WRIST, AV MALFORMATION EXCISION IN RIGHT WRIST ANTERIORLY DONE ON 09/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. ROXSAFE CV 500+125 MG THRICE DAILY AT 8AM 2PM, 8PM FOR 5 DAYS.

2) TAB. LINEZOLID 600 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

3) TAB. ULTRACET THRICE DAILY AT 8AM 2PM, 8PM FOR 5 DAYS.

REVIEW AFTER 5 DAYS TO CTVS OPD

ARH1.0001230519		**Name**	Mrs. JADAV BHIKKI BAI		
	Patient Identifier	ARHIP55583		**Age**	85Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	03-May-2022
	Date of Discharge				
	MLC No				
	Address	LINGAPUR,,Asifabad,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:111 A
	Primary Consultant	Dr Chandra Shekar Sathineni			

UROSEPSIS WITH SEPTIC SHOCK

C/o pain abdomen since 10 days
burning micturition since 1 week

Known case of hypertension on medication

AT ADMISSION:

Afebrile

PR: 75/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 85 years old female patient Mrs. JADAV BHIKKI BAI came with c/o pain abdomen since 10 days, burning micturition since 1 week. Known case of hypertension on medication. All necessary investigations were done and diagnosed as UROSEPSIS WITH SEPTIC SHOCK. Managed conservatively. Urologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. PAN-D 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.

3) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

4) TAB. CALPOL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230418		**Name**	Mr. SAMPATH KUMAR ARUKATI
Patient Identifier	ARHIP55593	**Age**	32Yr 0Mth 10Days
Sex	Male	**Date of Admission**	04-May-2022
Date of Discharge			
MLC No			
Address	MANTHANI,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:108 B
Primary Consultant	Dr. GOUTHAM ROY (MS(		

ACUTE APPENDICITIS
SURGERY: LAPROSCOPIC APPENDICECTOMY DONE ON 05.05.2022

C/o pain abdomen since 2 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 32yr old male patient Mr. SAMPATH KUMAR ARUKAT came with c/o pain abdomen since 2 days . All necessary investigations done and diagnosed as ACUTE APPENDICITIS, SURGERY: LAPROSCOPIC APPENDICECTOMY DONE ON 05.05.2022. Findings: Inflamed appendix retrocaecal position and adherent to retroperitoneum, Inflamed IC junction and surrounding moiety. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
4. TAB: PANTOCID-L **TWICE IN A DAY AT 8 AM 8 PM** 15 DAYS.
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001012134		**Name**	Mr. RAHEMUDDIN MD		
	Patient Identifier	ARHIP55564		**Age**	59Yr 9Mth 25Days
	Sex	Male		**Date of Admission**	30-Apr-2022
	Date of Discharge				
	MLC No				
	Address	9-3-160, SRINAGAR COLONY,Karimnagar,Andhra Pradesh		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:108 A
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

POSTERIOR CIRCULATION STROKE
HYPERTENSION, TYPE II DIABETES MELLITUS

C/o weakness of left upper limb and lower limb, slurring of speech, giddiness and generalised weakness since 2 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 59yr old male patient Mr. RAHEMUDDIN MD came with c/o weakness of left upper limb and lower limb, slurring of speech, giddiness and generalised weakness since 2 days. All necessary investigations done and diagnosed as POSTERIOR CIRCULATION STROKE, HYPERTENSION, TYPE II DIABETES MELLITUS. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: ATORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: CLOPITAB 75 MG ONCE DAILY AT 2 PM TO CONTINUE

Review after 7 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001230722		**Name**	Mrs. D SRILATHA
Patient Identifier	ARHIP55662	**Age**	44Yr 0Mth 0Days
Sex	Female	**Date of Admission**	09-May-2022
Date of Discharge			
MLC No			
Address	NTPC KRISHNA NAGAR GODAVARIKHANI,Karimnagar,Telangana	**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME5
Primary Consultant	Dr. GOUTHAM ROY (		

EPIDERMOID CYST OF THE BACK

SURGERY: BACK EPIDERMOID CYST EXCISION DONE ON 09.05.2022

C/o swelling over the back, midline thoracic region

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 44yr old female patient Mrs. D SRILATHA came with c/o swelling over the back, midline thoracic region. All necessary investigations done and diagnosed as EPIDERMOID CYST OF THE BACK, SURGERY: BACK EPIDERMOID CYST EXCISION DONE ON 09.05.2022. Findings: small cyst measuring 1 x 1 cm noted in the back over the midline in the thoracic region. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: ROTAVAULT THRICE DAILY **AT 8 AM 2PM 8 PM** 5 DAYS.
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001230530		**Name**	Mr. R VISHNU		
	Patient Identifier	ARHIP55637		**Age**	36Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	07-May-2022
	Date of Discharge				
	MLC No				
	Address	SIRICILLA,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR
MODERATE LV DYSFUNCTION, EF-35%
CORONARY ANGIOGRAM DONE ON 04/05/2022 – CAD-SVD (LAD)
PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022
R/F: DENOVO DIABETES

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 36 years old male patient Mr. R. VISHNU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 04/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION DONE ON 04/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG TWICE IN A DAY AT 8 AM 8 PM TO CONTINUE.

3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.

LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001171665		**Name**	Mr. MOHD AHMED		
	Patient Identifier	ARHIP55632		**Age**	59Yr 2Mth 26Days
	Sex	Male		**Date of Admission**	07-May-2022
	Date of Discharge	07-May-2022			
	MLC No				
	Address	BENDA PALLY KORUTLA,Karimnagar,Telangana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CAD UNSTABLE ANGINA
POST PCI-2019
CORONARY ANGIOGRAM DONE ON 7/5/2022-SVD(PLV)
RISK FACTOR:HYPERTENSION.DIABETES MELLITUS.

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old male patient Mr. MOHD AHMED came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD UNSTABLE ANGINA, POST PCI-2019, CORONARY ANGIOGRAM DONE ON 7/5/2022-SVD(PLV), PLAN FOR PTCA+DES TO PLV. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. SARTEL 40MG ONCE DAILY AT 2PM TO CONTINUE.

2. TAB. ANGISPAN TR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CLOPITAB-A 105+75MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB: GLIMCORD M3 FORTE ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001079469		**Name**	Mrs. HAMDABI MD		
	Patient Identifier	ARHIP55620		**Age**	61Yr 0Mth 24Days
	Sex	Female		**Date of Admission**	06-May-2022
	Date of Discharge				
	MLC No				
	Address	1-18 KONDAPALLIKI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 7
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI, SR

SEVERE LV SYSTOLIC DYSFUNCTION

S/P OLD CAD PTCA STENT TO LAD (2015)

CORONARY ANGIOGRAM (09/05/2022) -CAD-SVD (Mild ISR-Proximal LAD)

PLAN MEDICAL MANAGEMENT

R/F : HTN, HYPOTHYRIDISM

C/o left sided chest pain associated with palpitations since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old female patient Mrs. HAMDABI MD came with c/o left sided chest pain associated with palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, SEVERE LV SYSTOLIC DYSFUNCTION, S/P OLD CAD PTCA STENT TO LAD (2015), CORONARY ANGIOGRAM (09/05/2022) -CAD-SVD (Mild ISR-Proximal LAD), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDIVAS 6.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. THYRONORM 100MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
6. TAB. DYTOR 5MG ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230338		**Name**	Mr. NIMMALA POCHAIAH
Patient Identifier	ARHIP55516	**Age**	62Yr 3Mth 13Days
Sex	Male	**Date of Admission**	27-Apr-2022
Date of Discharge			
MLC No			
Address	5-6-218, MARUTHI NAGAR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 2
Primary Consultant	Dr SOMASHEKAR K(MS,MCH		

CHRONIC RHEUMATIC HEART DISEASE + SEVERE MS+MR+SEVERE AS WITH AR+ATRIAL FLUTTER WITH FAST VENTRICULAR RATE

SURGERY: **DOUBLE VALVE REPLACEMENT** [AVR WITH SJ NO. 21 MM & MVR WITH SJ NO. 23MM MECHANICAL VALVES] DONE ON 04/05/2022.

C/o shortness of breath on exertion since 10 days

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 62 years old male patient Mr. NIMMALA POCHAIAH came with c/o shortness of breath on exertion since 10 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE + SEVERE MS+MR+SEVERE AS WITH AR+ATRIAL FLUTTER WITH FAST VENTRICULAR RATE, **SURGERY: DOUBLE VALVE REPLACEMENT** [AVR WITH SJ NO. 21 MM & MVR WITH SJ NO. 23MM MECHANICAL VALVES] DONE ON 04/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST DVR 2D ECHO REPORTS SHOWED POST DVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL FUNCTIONING PROSTHETIC MITRAL VALVE, MODERATE TR/ PAH. NO CLOT/PE/VEG

BMI is 22.3 kg/m2.

Sr. Creatinine report on 05/05/2022 1.0 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. ACITROM 2 MG & 1MG ALTERNATE DAY AT 7PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. FLECAINIDE 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.

5) TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

55625

LOWER RESPIRATORY TRACT INFECTION
RENAL INSUFFICIENCY

C/o pain abdomen, cough, vomiting and shortness of breath since 5 days

Known case of hypertension, type II diabetic mellitus, chronic kidney disease, COPD

AT ADMISSION:

Afebrile

PR: 72/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old male patient NARAYANA came with c/o pain abdomen, cough, vomiting and shortness of breath since 5 days. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION,
RENAL INSUFFICIENCY. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

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1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) TAB. BILAHENZE M ONCE DAILY AT 8PM FOR 7 DAYS

5) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230643		**Name**	Mr. RAMULU G
Patient Identifier	ARHIP55626	**Age**	50Yr 0Mth 3Days
Sex	Male	**Date of Admission**	07-May-2022
Date of Discharge	07-May-2022		
MLC No			
Address	KMR,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Female General Ward, Bed no:GW 5
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

CEREBRO VASCULAR ACCIDENT ACUTE INFRACT ON LEFT LARGE MCA INFRACT

C/o sudden slip and fall at home followed by unable to work and stand

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 50 years old male patient RAMULU came with c/o sudden slip and fall at home followed by unable to work and stand. All necessary investigations were done and diagnosed as CEREBRO VASCULAR ACCIDENT ACUTE INFRACT ON LEFT LARGE MCA INFRACT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001215895		**Name**	Mrs. D RENUKA
Patient Identifier	ARHIP55547	**Age**	30Yr 10Mth 8Days
Sex	Female	**Date of Admission**	29-Apr-2022
Date of Discharge			
MLC No			
Address	RAJEEV NAGAR RAJANNA SIRCILLA ,Sircilla,Telangana	**Ward/Bed No**	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Consultants**	
Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP55547	ARH1.000121589

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
AORTIC VALVE REPLACEMENT	06			

CHRONIC RHEUMATIC HEART DISEASE WITH SEVERE AR

SURGERY: AORTIC VALVE REPLACEMENT WITH SJ NO 19 MM MECHANICAL VALVE DONE ON 06/05/2022

C/o SOB on exertion since 2 weeks

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+,

P/A-Soft,

SPO2-98%

A 30 years old female patient RENUKA presented to hospital with c/o SOB on exertion since 2 weeks. All necessary investigations were done and diagnosed as CRHD WITH SEVERE AR+AS, **SURGERY:** AORTIC VALVE REPLACEMENT WITH SJ NO 19 MM MECHANICAL VALVE DONE ON 06/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

POST AVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, MILD LV DYSFUNCTION, NO VALVULAR /PARAVALVULAR LEAK, EF-50%.

BMI is 20.3 kg/m2

Sr. Creatinine report on 07/05/2022 1.0 mg/dl

DISCHARGE MEDICATION:

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1) TAB. ACITROM 1MG ONCE DAILY AT 7PM TO CONTINUE LIFE LONG.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. MET-XL 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

5) TAB. ALPRAX 0.25MG ONCE DAILY AT 9PM (HS) FOR 5 DAYS.

6) TAB. DOXY 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

9) TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

Saleem

ARH1.0001230697		**Name**	Mr. MOHAMMAD SALEEM		
	Patient Identifier	ARHIP55646		**Age**	45Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	08-May-2022
	Date of Discharge				
	MLC No				
	Address	Jagital,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 2
	Primary Consultant	Dr Chandra Shekar Sathineni			

MULTIORGAN DYSFUNCTION SYNDROME
HYPERTENSION
DIABETES MELLITUS
PERIPHERAL ARTERIAL DISEASE
RIGHT DIABETIC FOOT
LOWER RESPIRATORY TRACT INFECTION
RENAL INSUFFICIENCY

C/o shortness of breath associated with pedal oedema since 1 day
Alleged history of trauma sustained injury to right lower limb

AT ADMISSION:

Afebrile

PR: 124/min

BP: 180/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 45 years old male patient MOHAMMAD SALEEM came with c/o shortness of breath associated with pedal oedema since 1 day, alleged history of trauma sustained injury to right lower limb. All necessary investigations were done and diagnosed as MULTIORGAN DYSFUNCTION SYNDROME, HYPERTENSION, DIABETES MELLITUS,
PERIPHERAL ARTERIAL DISEASE, RIGHT DIABETIC FOOT, LOWER RESPIRATORY TRACT INFECTION, RENAL INSUFFICIENCY . Managed conservatively. General Surgeon consultation taken in view of right diabetic foot and advised followed. Patient attendants requested for discharge, hence patient is being discharge at request.
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DISCHARGE MEDICATION:

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1) TAB. FEROALFA –CV TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. DOPAGYL 10 MG ONCE DAILY AT 2PM FOR 10 DAYS.

4) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

5) TAB. BILAHENZ ONCE DAILY AT 2PM FOR 10 DAYS.

6) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 10 DAYS.

7) TAB. RENOSAVE ONCE DAILY AT 2PM FOR 10 DAYS.

8) TAB. PLETOZ 100 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.

9) TAB. NICARDIA 20 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.

10) CAP. VSL# 3 ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230767		**Name**	Mrs. ZAREENA BEGUM		
	Patient Identifier	ARHIP55682		**Age**	59Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	10-May-2022
	Date of Discharge				
	MLC No				
	Address	bellampalli,Mancherial,Telangana		**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME7
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, TLT WITH TNK (07/05/2022)

MILD MR, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

R/F : T2DM, HTN

CORONARY ANGIOGRAM (10/05/2022) -CAD-SVD (Recanalized RCA)

ADV: MEDICAL MANAGEMENT

C/o chest pain, SOB on exertion since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 56/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old female patient Mrs. ZAREENA BEGUM came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, TLT WITH TNK (07/05/2022), MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], R/F : T2DM, HTN, CORONARY ANGIOGRAM (10/05/2022) -CAD-SVD (Recanalized RCA), ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. GLYCOMET 500MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLYCOMET SR P2 850 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. AMLOKIND 80 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230739		**Name**	Mr. RAMAGIRI SATHAIAH		
	Patient Identifier	ARHIP55673		**Age**	68Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	09-May-2022
	Date of Discharge				
	MLC No				
	Address	Jagital Jaina,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

DCMP, LBBB, MODERATE MR, SR,

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

R/F DENOVO T2DM, HTN, ALCOHOL, Br. ASTHMA

C/o severe SOB grade-IV, burning sensation in chest

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 68 years old male patient Mr. RAMAGIRI SATHAIAH came with c/o severe SOB grade-IV, burning sensation in chest. All necessary investigations were done and diagnosed as DCMP, LBBB, MODERATE MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], R/F DENOVO T2DM, HTN, ALCOHOL, Br. ASTHMA. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2. TAB. CARDIVAS 6.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3. TAB. ALDACTONE 25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4. TAB. CIDMUS 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5. TAB. SEROFLOW 250 MG 1 PUFF TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229475		**Name**	Mrs. M LAXMI		
	Patient Identifier	ARHIP55690		**Age**	57Yr 1Mth 11Days
	Sex	Female		**Date of Admission**	11-May-2022
	Date of Discharge				
	MLC No				
	Address	SATHRAJPALLY, VEMULAWADA,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 2
	Primary Consultant	Dr. Iftekarali (MS (Orthopaedics			

POST-OPERATIVE CASE OF SUPRACONDYLAR FRACTURE RIGHT HUMERUS TO K-WIRE REMOVAL

SURGERY : K-WIRE REMOVAL DONE ON 11/05/2022

Patient came for K-wire removal

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-98/min
BP-120/80mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 57 years old female patient Mrs. M LAXMI came for k-wire removal . All necessary investigations were done and diagnosed as POST-OPERATIVE CASE OF SUPRACONDYLAR FRACTURE RIGHT HUMERUS TO K-WIRE REMOVAL, SURGERY : K-WIRE REMOVAL DONE ON 11/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
4. TAB. DISENCHER **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.
5. TAB. CALCIMAX **ONCE IN A DAY AT 2 PM** FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO DR. IFTEKARALI SIR OPD.

Avr somasekar
Venkatreddy tkr vr
Cemented bipolar iftek
Mastectomy goutham roy
Pcnl
Pcnl
ursl

ARH1.0001230602		**Name**	Mrs. NOOKALA MALLU		
	Patient Identifier	ARHIP55623		**Age**	65Yr 0Mth 5Days
	Sex	Female		**Date of Admission**	07-May-2022
	Expired Date	10-May-2022			
	MLC No				
	Address	chennur,Mancherial,Telangana		**Ward/Bed No**	First Floor, CT POST, Bed no:CT 6
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE .TRIPPLE VESSELE DISEASE .SEVERE LV DISFUNCTION .CADIOGENIC SHOCK. NSTEMI. VENTRICULAR ARRTHYMIA.	

C/o chest pain since 3 days

AT ADMISSION:
PR: 72/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 65 years old female patient Mrs. NOOKALA MALLU came with c/o chest pain since 3

days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE .TRIPPLE VESSELE DISEASE .SEVERE LV DISFUNCTION .CADIOGENIC SHOCK. NSTEMI. VENTRICULAR ARRTHYMIA. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.15 AM on 10/05/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO SEVERE LV DYSFUNCTION, CAD-TVD

ARH1.0001171665		**Name**	Mr. MOHD AHMED		
	Patient Identifier	ARHIP55661		**Age**	59Yr 2Mth 28Days
	Sex	Male		**Date of Admission**	09-May-2022
	Date of Discharge				
	MLC No				
	Address	BENDA PALLY KORUTLA,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU1 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NON STEMI, SR
NORMAL LV FUNCTION, EF-60%
S/P PTCA 2019
CORONARY ANGIOGRAM DONE ON 7/5/2022-CAD-SVD(PLV)
PLAN : PTCA+DES TO PLV

C/o chest pain since 1 day

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 82/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 59 years old male patient Mr. MOHD AHMED came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON STEMI, SR, NORMAL LV FUNCTION, EF-60%, S/P PTCA 2019, CORONARY ANGIOGRAM DONE ON 7/5/2022-CAD-SVD(PLV), PLAN : PTCA+DES TO PLV. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:
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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4. TAB. PREVAMET-AM 50MG ONCE DAILY AT 8AM TO CONTINUE.

5. TAB. GLIMICARD M3 FORTE ONCE DAILY AT2PM TO CONTINUE.

6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230710		**Name**	Mrs. AMAD BHEE MAHAMMAD		
	Patient Identifier	ARHIP55671		**Age**	56Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	09-May-2022
	Date of Discharge				
	MLC No				
	Address	ASIFNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ISCHAEMIC CARDIOMYOPATHY

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 12/05/2022 – CAD-DVD (LAD,RCA)

PLAN CABG.

R/F CKD, T2DM, CKD, ANAEMIA, Br.ASTHMA, DYSLIPIKEMIA

C/o chest pain, SOB on exertion since 1 day

At Admission

Afebrile

PR: 70/min

BP: 130/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-95%

A 56 years old female patient Mrs. AMAD BHEE MAHAMMAD came with c/o chest pain, SOB on exertion since 1 day. All necessary investigations were done and diagnosed as ISCHAEMIC CARDIOMYOPATHY, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 12/05/2022 – CAD-DVD (LAD, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. CLOPITAB-A 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. CARDIVAS 6.25 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. MONOTRATE 10 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FRUSELOC ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. FORACORT 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. ZORYL-M1 ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. VOGS 0.3 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001111763		**Name**	Mr. VENU MADHAV SINGARI		
	Patient Identifier	ARHIP55713		**Age**	49Yr 9Mth 16Days
	Sex	Male		**Date of Admission**	13-May-2022
	Date of Discharge				
	MLC No				
	Address	9-9-185/1, LAXMI NILAYAM RAM NAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 3
	Primary Consultant	Dr. GOUTHAM ROY (MS			

BALANITIS WITH PHIMOSIS + ACUTE FISSURE IN ANO
SURGERY: CIRCUMCISSION+LATERAL ANAL SPHINCTEROTOMY+ANAL DILATATION DONE ON 13/05/22

C/o perineal pain, swelling since 1-2 months

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-71/min

BP-100/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 49 yrs old male patient Mr. VENU MADHAV SINGARI came with c/o perineal pain, swelling since 1-2 months. All necessary investigations done and diagnosed as BALANITIS WITH PHIMOSIS + ACUTE FISSURE IN ANO, SURGERY: CIRCUMCISION + LATERAL SPHINCTERECTOMY +ANAL DILATATION DONE ON 14/05/2022. Findings: Dorsal slit technique followed and frenular artery ligated and prepenal skin excised, Severe anal spasm noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. T-BACT OINTMENT FOR L/A
5. SITZ BATH TWICE DAILY
6. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
7. XYLOCAINE JELLY EVERY 4th hrly

Review after 7 days in General Surgery OPD.

ARH1.0001230776		**Name**	Mrs. GOUSEIYA BEGAM
Patient Identifier	ARHIP55687	**Age**	45Yr 0Mth 3Days
Sex	Female	**Date of Admission**	11-May-2022
Date of Discharge			
MLC No			
Address	0-0 Shatrajupalli,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 6
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 16 MM 3V ASTRA DONE ON 11/05/2022

C/o chest pain a/w palpitations since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 45 years old female patient Mrs. GOUSEIYA BEGAM came with c/o chest pain a/w palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, R/F: T2DM, CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 16 MM 3V ASTRA [LOT NO: 240335016042A, S/N :22035162121] DONE ON 11/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

4) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230694		**Name**	Mrs. MUJEEB UNNISA
Patient Identifier	ARHIP55672	**Age**	61Yr 0Mth 7Days
Sex	Female	**Date of Admission**	09-May-2022
Date of Discharge			
MLC No			
Address	jagityal,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 20 MM 3V ASTRA DONE ON 11/05/2022
R/F: T2DM, HTN, HYPOTHYROIDISM

C/o chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 61 years old female patient Mrs. MUJEEB UNNISA came with c/o chest pain since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 20 MM 3V ASTRA [LOT NO: 240330020048A, S/N :22034205034] DONE ON 11/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. OLOMET-VG2 TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

5) TAB. THYRONORM 75MCG ONCE DAILY AT 7AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230807		**Name**	Mr. AJITH DUDEKULA
Patient Identifier	ARHIP55694	**Age**	35Yr 0Mth 3Days
Sex	Male	**Date of Admission**	11-May-2022
Date of Discharge			
MLC No			
Address	H.NO:3-17,DHARMARAM,MALLAPUR,JAGITIAL,Other,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

S

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

NORMAL LV FUNCTION, EF-55%

CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (RCA)

PTCA TO RCA DONE ON 11/05/2022
R/F: ALCOHOLIC

C/o chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 88/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 35 years old male patient Mr. AJITH DUDEKULA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, NORMAL LV FUNCTION, EF-55%, CORONARY ANGIOGRAM DONE ON 11/05/2022 – CAD-SVD (RCA), PTCA TO RCA DONE ON 11/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ROSAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001192105		**Name**	Mr. ILLANDULA RAMULU		
	Patient Identifier	ARHIP55522		**Age**	63Yr 2Mth 16Days
	Sex	Male		**Date of Admission**	27-Apr-2022
	Date of Discharge				
	MLC No				
	Address	7-25,LAXMIPUR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 10
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

ACUTE RIGHT MCA INFARCT

AKI

AF WITH FVR

C/o slurring of speech, sudden in onset of left sided weakness

AT ADMISSION:

Afebrile

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old male patient Mr. ILLANDULA RAMULU came with c/o slurring of speech, sudden in onset of left sided weakness . All necessary investigations were done and diagnosed as ACUTE RIGHT MCA INFARCT, AKI, AF WITH FVR. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB: CLOPITAB 75 MG ONCE DAILY AT 8AM TO CONTINUE
2. TAB: SOBNEX ONCE DAILY AT 8AM TO CONTINUE
3. TAB: KETOCHECK TWICE DAILY AT 8AM 8PM TO CONTINUE
4. TAB: CUDCE TWICE DAILY AT 8AM 8PM TO CONTINUE
5. TAB: PROLOMET XL 50 MG TWICE DAILY AT 8AM 8PM TO CONTINUE
6. TAB: IXAROLA 15MG ONCE DAILY AT 8AM TO CONTINUE
7. TAB: ROSEDAY 10MG ONCE DAILY AT 8PM TO CONTINUE

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001230848		**Name**	Mr. M SRINIVAS
Patient Identifier	ARHIP55712	**Age**	42Yr 0Mth 2Days
Sex	Male	**Date of Admission**	12-May-2022
Date of Discharge			
MLC No			
Address	KORUTLA, JAGITYAL,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

S

CORONARY ARTERY DISEASE, NSTEMI, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

S/P POST PTCA TO LAD

CORONARY ANGIOGRAM DONE ON 14/05/2022 – CAD-PROXIMAL LAD MILD ISR WITH ANEURYSM AND THROMBUS

PLAN CABG WITH GRAFT TO LAD, D1

R/F: HTN, T2DM

C/o chest pain, radiating to the back since 2 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 42 years old male patient Mr. SRINIVAS came with c/o chest pain, radiating to the back since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, S/P POST PTCA TO LAD , CORONARY ANGIOGRAM DONE ON 14/05/2022 – CAD-PROXIMAL LAD MILD ISR WITH ANEURYSM AND THROMBUS, PLAN CABG WITH GRAFT TO LAD, D1. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TICASAVE 90 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. ZORYL M FORTE ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. SARTEL-C 40 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. PANTOCID 40MG ONCE DAILY AT 7AM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

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ARH1.0001230136		**Name**	Mr. SYED ASADULLA HUSSAIN		
	Patient Identifier	ARHIP55648		**Age**	62Yr 0Mth 21Days
	Sex	Male		**Date of Admission**	08-May-2022
	Expired Date	12-May-2022			
	MLC No				
	Address	hussenipura,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
ACUTE LEFT VENTRICULAR FAILURE SEVERE LV SYSTOLIC DYSFUNTION S/P: POST PTCA TO RCA R/F:DIABETES MELLITUS.	

C/o SOB since 7 days, b/l pedal edema

AT ADMISSION:

PR: 81/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. SYED ASADULLA HUSSAIN came with c/o SOB since 7 days, b/l pedal edema. All necessary investigations were done and diagnosed as ACUTE LEFT VENTRICULAR FAILURE
SEVERE LV SYSTOLIC DYSFUNTION, S/P: POST PTCA TO RCA, R/F:DIABETES MELLITUS CONGESTIVE CARDIAC FAILURE,SEVERE LV DYSFUNCTION,MODERATE MR,SEVERE TR&HOLLOW VISCUS PERFORATION. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.19 AM on 12/05/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEVERE HYPOTENSION, BRADY CARDIA, SEVERE LVF, S/P PTCA

ARH1.0001225314		**Name**	Mr. MUJEEB KHAN
Patient Identifier	ARHIP55635	**Age**	42Yr 5Mth 5Days
Sex	Male	**Date of Admission**	07-May-2022
Date of Discharge			
MLC No			
Address	PEDDAPALLY,Karimnagar,Telanga	**Ward/Bed No**	First Floor, CT

	na		POST, Bed no:CT 3
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Consultants**	
Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP55635	ARH1.000122531

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
Femoro papliteal art Bypass Grafting				

PAD WITH ATHEROSCLEROTIC BLOCK IN RIGHT POPLTEAL ARTERY

SURGERY – FEMORO PAPLITEAL ART BYPASS GRAFTING USING 6 MM PTFE GRAFT DONE ON 11/05/2022.

C/o pain in b/l lower limbs

K/c/o HTN, CRHD with MS+AF

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 42 years old male patient Mr. MUJEEB KHAN presented to hospital with c/o pain in b/l lower limbs. All necessary investigations were done and diagnosed as PAD WITH ATHEROSCLEROTIC BLOCK IN RIGHT POPLTEAL ARTERY, SURGERY – FEMORO PAPLITEAL ART BYPASS GRAFTING USING 6 MM PTFE GRAFT DONE ON 11/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. MET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. ENCORATE CHRONO 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. ACITROM 2 MG ONCE IN A DAY AT 7PM TO CONTINUE.

6) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

7) TAB. LINEZOLID 600 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

9) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230810		**Name**	Mrs. RAJESHWARI PENTA		
	Patient Identifier	ARHIP55701		**Age**	64Yr 0Mth 5Days
	Sex	Female		**Date of Admission**	12-May-2022
	Date of Discharge				
	MLC No				
	Address	2-191, KACHAPOOR,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 13/05/2022 – CAD-DVD (LAD, RAMUS)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR, RAMUS WITH 2.75 X 16 MM METAFOR DONE ON 13/05/2022
R/F: HTN

C/o SOB on exertion, chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/790mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 64 years old female patient Mrs. RAJESHWARI PENTA came with c/o SOB on exertion, chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 13/05/2022 – CAD-DVD (LAD, RAMUS), PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR, RAMUS WITH 2.75 X 16 MM METAFOR [LOT NO: MH41, S/N :CM29MH41013], [LOT NO: MH21, S/N :CM16MH21020] DONE ON 13/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001204954		**Name**	Mrs. B LAXMI		
	Patient Identifier	ARHIP55653		**Age**	76Yr 2Mth 27Days
	Sex	Female		**Date of Admission**	09-May-2022
	Expired Date	09-May-2022			
	MLC No				
	Address	karimnagar,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
ISCHEMIC CARDIOMYOPATHY,SEVER MR AF,SEVER LVDYSFUNCTION.	

C/o chest pain a/w SOB since 1 days

AT ADMISSION:

PR: 131/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 76 years old female patient Mrs. B LAXMI came with c/o chest pain a/w SOB since 1 days. All necessary investigations were done and diagnosed as ISCHEMIC CARDIOMYOPATHY,SEVER MR AF,SEVER LVDYSFUNCTION. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 07.41 PM on 09/05/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ISCHEMIC CARDIOMYOPATHY,SEVER MR AF,SEVER LVDYSFUNCTION

ARH1.0001230626		**Name**	Mrs. A SUGUNA	
Patient Identifier	ARHIP55612		**Age**	55Yr 0Mth 10Days
Sex	Female		**Date of Admission**	06-May-2022
Date of Discharge	06-May-2022			
MLC No				
Address	karimnmagar,Karimnagar,Telangana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 1

Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**

Diagnosis

Diagnosis

Disease	Disease Type
.	

CORONARY ARTERY DISEASE CHEST PAIN
NORMAL LV FUNCTION EF-60%
CORONARY ANGIOGRAM ON(6/5/2022)
PLAN-MEDICAL MANAGEMENT

Patient came for pre-operative evaluation for ECG changes

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old female patient SUGUNA came for pre-operative evaluation for ECG changes. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE CHEST PAIN
NORMAL LV FUNCTION EF-60%, CORONARY ANGIOGRAM ON(6/5/2022), PLAN-MEDICAL MANAGEMENT.

Patient advised to take TAB ECOSPRIN 150 MG daily after lunch [To be started after knee replacement]. Patient is being discharged in hemodynamically stable condition with required medication and advice.

ARH1.0001230708		**Name**	Mr. JUPAKA RAJESH
Patient Identifier	ARHIP55718	**Age**	35Yr 0Mth 7Days
Sex	Male	**Date of Admission**	13-May-2022
Date of Discharge	13-May-2022		
MLC No			
Address	MANDAMARRI,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

A TYPICAL CHEST PAIN
CORONARY ARTERY DISEASE-TMT POSITIVE
CORONARY ANGIOGRAM DONE ON 13/05/2022
PLAN:MEDICAL MANAGEMENT

C/o chest pain since 2 months on and off a/w SOB on exertion

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 84/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 35 years old male patient Mr. JUPAKA RAJESH came with c/o chest pain since 2 months on and off a/w SOB on exertion. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001021325		**Name**	Mr. KASARAPUR RAMACHANDRAM		
	Patient Identifier	ARHIP55728		**Age**	50Yr 1Mth 16Days
	Sex	Male		**Date of Admission**	15-May-2022
	Date of Discharge				
	MLC No				
	Address	KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 8
	Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal			

METABOLIC ENCEPHALOPATHY
ALCOHOL WITHDRAWAL
CVA

C/o sudden weakness of right upper and lower limb associated with 2 episodes of vomitings and right side deviation of mouth
H/o CAD

AT ADMISSION:

O/E patient is conscious, mild drowsy

Afebrile

PR: 73/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. KASARAPUR RAMACHANDRAM came with c/o sudden weakness of right upper and lower limb associated with 2 episodes of vomitings and right side deviation of mouth, decreased urine output . All necessary investigations were done and diagnosed as METABOLIC ENCEPHALOPATHY, ALCOHOL WITHDRAWAL, CVA. Managed conservatively. Cardiologist and Neurophysician consultations taken and advice followed. Patient attendants requested for discharge, hence patient is being discharge at request and referred to higher center for further management.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN GOLD 20 MG ONCE DAILY AT 2 PM FOR 5 DAYS

2) TAB. LIBRIUM 10 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

3) TAB. BENFOMET FORTE ONCE DAILY AT 2 PM FOR 5 DAYS

4) TAB. PAN-D 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230708		**Name**	Mr. JUPAKA RAJESH
Patient Identifier	ARHIP55718	**Age**	35Yr 0Mth 7Days
Sex	Male	**Date of Admission**	13-May-2022
Date of Discharge	13-May-2022		
MLC No			
Address	MANDAMARRI,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
A TYPICAL CHEST PAIN CORONARY ARTERY DISEASE-TMT POSITIVE CORONARY ANGIOGRAM DONE ON 13/05/2022 PLAN:MEDICAL MANAGEMENT.	

C/o chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 35 years old male patient Mr. JUPAKA RAJESH came with c/o chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as A TYPICAL CHEST PAIN, CORONARY ARTERY DISEASE-TMT POSITIVE, CORONARY ANGIOGRAM DONE ON 13/05/2022, PLAN:MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN AV 75MG ONCE DAILY AFTER DINNER TO CONTINUE.

2. TAB. VELOZ 20 MG ONCE DAILY BEFORE BREAKFAST FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001230822		**Name**	Mrs. POCHAMMA AKKAPAKA
Patient Identifier	ARHIP55709	**Age**	64Yr 0Mth 5Days
Sex	Female	**Date of Admission**	12-May-2022
Date of Discharge			
MLC No			
Address	GODAVARIKANI,Ramagundam,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 2
Primary Consultant	Dr. GOUTHAM ROY (MS(General		

EPIGASTRIC HERNIA

SURGERY: OPEN EPIGASTRIC HERNIA REPAIR DONE ON 14.05.2022

C/o swelling over epigastric region

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 64yr old female patient Mrs. POCHAMMA AKKAPAKA came with c/o swelling over epigastric region. All necessary investigations done and diagnosed as EPIGASTRIC HERNIA, SURGERY: OPEN EPIGASTRIC HERNIA REPAIR DONE ON 14.05.2022. Findings: Defect measuring 3 x 2 cm noted in the epigastric region omentum as its content. Pulmonologist consultation taken and advice followed. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
2. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 10 DAYS
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
6. SPIROMETRY EXERCISES
7. AZEFLO NASAL SPRAY TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
   AZEFLO NASAL SPRAY ONCE DAILY AT 8PM FOR 15 DAYS
8. TAB. MONTEK AB ONCE DAILY AT 8PM FOR 10 DAYS

Review after 7 days in General Surgery OPD.

ARH1.0001204623		**Name**	Mrs. KANDE LASMAKKA
Patient Identifier	ARHIP55601	**Age**	69Yr 3Mth 11Days
Sex	Female	**Date of Admission**	05-May-2022
Date of Discharge			
MLC No			
Address	ladnapur, peddapally,,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 4
Primary Consultant	Dr SOMASHEKAR K(MS,MCH		

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CHRONIC RHEUMATOID HEART DISEASE WITH SEVERE MITRAL REGURGITATION, MVP WITH SEVERE MITRAL REGURGITATION + **CEREBRAL VASCULAR ACCIDENT, HYPERTENSION**
SURGERY: MVR WITH SJ NO. 31 MM, MECHANICAL VALVE DONE ON 10/05/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 69 years old female patient Mrs. KANDE LASMAKKA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATOID HEART DISEASE WITH SEVERE MITRAL REGURGITATION, ?MVP WITH SEVERE MITRAL REGURGITATION + **CEREBRAL VASCULAR ACCIDENT, HYPERTENSION,** SURGERY: MVR WITH SJ NO. 31 MM, MECHANICAL VALVE DONE ON 10/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL FUNCTIONING PROSTHETIC MITRAL VALVE, MILD LV DYSFUNCTION. NO CLOT/PE/VEG

BMI is 20.2 kg/m2.

Sr. Creatinine report done on 11.05.2022 0.9 mg/dl

DISCHARGE MEDICATION:

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1) TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE FOR LIFE LONG.

2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE

4) TAB. CLOPILET –A 75+150 MG ONCE DAILY AT 2PM TO CONTINUE.

5) TAB. ROZAVEL 20 MG ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. DIXIN 0.25 MG ONCE DAILY AT 2PM TO CONTINUE.

7) TAB. MET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

8) TAB. CARDARONE 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

9) TAB. COLPOL 500MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

10)TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

11) TAB. LIZOLID 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

REVIEW AFTER 11 DAYS TO NEUROPHYSICIAN OPD

ARH1.0001230808		**Name**	Mrs. KASAM BHUMAKKA		
	Patient Identifier	ARHIP55700		**Age**	80Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	11-May-2022
	Date of Discharge				
	MLC No				
	Address	KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

ACUTE AND CHRONIC SDH (LEFT > RIGHT)
CONSERVATIVE MANAGEMENT

C/o sudden onset of right upper and lower limb since 2 days associated with slurring of speech and deviation of angle of mouth to left
History of fever since 2 days

AT ADMISSION:

Patient conscious incoherent cooperative
Febrile 101
PR: 93/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 80 years old female patient Mrs. KASAM BHUMAKKA came with c/o sudden onset of right upper and lower limb since 2 days associated with slurring of speech and deviation of angle of mouth to left, history of fever since 2 days. All necessary investigations were done and diagnosed as ACUTE AND CHRONIC SDH LEFT MORE THAN RIGHT
CONSERVATIVE MANAGEMENT. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:
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1) TAB. BENFOMET FORTE ONCE DAILY AT 2 PM FOR 5 DAYS

2) TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

3) SYP. GLYCEROL 2 TSP **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

DR. SAI SURYA

55686

COMPLETE HEART BLOCK,
NORMAL LV SYSTOLIC FUNCTION, EF-60%,
TPI DONE ON 14/05/2022,

PERMANENT PACEMAKER IMPLANTATION DONE ON 14/05/2022 (MEDTRONIC VVIR) MODEL:S/N 540026516G

AMPOXIN

55613

ARH1.0001230440		**Name**	Ms. J VIJAYA		
	Patient Identifier	ARHIP55613		**Age**	46Yr 0Mth 17Days
	Sex	Female		**Date of Admission**	06-May-2022
	Date of Discharge				
	MLC No				
	Address	GODAVARIKHANI ,Ramagundam,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 2
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant			

SEVERE CALCIFIC AORTIC VALVE STENOSIS IN A BICUSPID VALVE RIGHT, HYPOTHYROIDISM
SURGERY: AORTIC VALVE REPLACEMENT WITH SJ NO 17 MM MECHANICAL VALVE DONE ON 13/05/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 46 years old female patient Mrs. VIJAYA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as SEVERE CALCIFIC AORTIC VALVE STENOSIS IN A BICUSPID VALVE RIGHT, HYPOTHYROIDISM, SURGERY: AORTIC VALVE REPLACEMENT WITH SJ NO 17 MM MECHANICAL VALVE DONE ON 13/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST AVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL LV FUNCTION. NO CLOT/PE/VEG

BMI is ___ kg/m2.

Sr. Creatinine report done on 14.05.2022 0.9 mg/dl

DISCHARGE MEDICATION:

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1) TAB. ACITROM 1 MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE FOR LIFE LONG.

2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE

4) TAB. THYRONORM 50 MG ONCE DAILY AT 7AM BBF TO CONTINUE.

5) TAB. MET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. COLPOL 500MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

7)TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230967		**Name**	Mr. SHAIK ANWAR		
	Patient Identifier	ARHIP55753		**Age**	50Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	16-May-2022
	Date of Discharge				
	MLC No				
	Address	00, VILASNAGAR,JAYASHANKAR9394052728,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW17
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

RIGHT MIDBRAIN INFARCT
AF WITH CONTROLLED VR

H/o diplopia since 3 days a/w giddiness
known case of CAD
S/P CABG 2010

AT ADMISSION:

Afebrile

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old male patient Mr. SHAIK ANWAR came with h/o diplopia since 3 days a/w giddiness, known case of CAD, S/P CABG 2010. All necessary investigations were done and diagnosed as RIGHT MIDBRAIN INFARCT , AF WITH CONTROLLED VR. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001230923		**Name**	Mr. RAMULU GADE		
	Patient Identifier	ARHIP55729		**Age**	65Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	15-May-2022
	Date of Discharge				
	MLC No				
	Address	SANGAMALLAIAH PALLE,Mancherial,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, SR, NO TLT

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 15/05/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 18 MM XIENCE XPEDITION DONE ON 15/05/2022
R/F: HYPERTENSION

C/o Retrosternal chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. RAMULU GADE came with c/o retrosternal chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, SR, NO TLT, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 15/05/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 18 MM XIENCE XPEDITION DONE ON 15/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001093693		**Name**	Mrs. MAHEMOODA BEGUM		
	Patient Identifier	ARHIP55746		**Age**	81Yr 6Mth 6Days
	Sex	Female		**Date of Admission**	16-May-2022
	Date of Discharge	17-May-2022			
	MLC No				
	Address	KAKATIYA COLONY,Warangal,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

ACUTE KIDNEY INJURY WITH HPERKALEMIA

C/o shortness of breath grade-3 since few days, drowsiness+

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/870mmHg

RS: BAE+

CVS: S1S2

RR: 17/min

SPO2: 98%

P/A: Soft

A 81 years old female patient Mrs. MAHEMOODA BEGUM came with c/o shortness of breath grade-3 since few days, drowsiness+. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY WITH HPERKALEMIA. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

APJ1.0016600148		**Name**	Mr. VELPUR SACHIN
Patient Identifier	ARHIP55738	**Age**	29Yr 3Mth 11Days
Sex	Male	**Date of Admission**	16-May-2022
Date of Discharge			
MLC No			
Address	FLOT NO: 102, SRI SAI LAXMI APARTMENTS, GANGASTAN PHASE 1,Nizamabad,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 5
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP55738	APJ1.0016600014

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LIFT(LIGATION OF INTERSHINECTERIC FISTULOUS TRACT)				

INTERSPHINCTERIC FISSURE IN ANO
SURGERY: LIFT(LIGATION OF INTERSHINECTERIC FISTULOUS TRACT) DONE ON 13/05/22

C/o pain and discharge around the anus

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-81/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 29 yrs old male patient Mr. VELPUR SACHIN came with c/o pain and discharge around the anus. All necessary investigations done and diagnosed as INTERSPHINCTERIC FISSURE IN ANO, SURGERY: LIFT(LIGATION OF INTERSHINECTERIC FISTULOUS TRACT) DONE ON 13/05/22. Findings: Small tract measuring 2 cm with rectal opening at 7 o'clock position and inferior opening at 6 o'clock. Post operative period was uneventful. Neurophysician consultation taken and advice followed. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. METROGYL-P OINTMENT L/A THRICE DAILY
4. XYLOCAINE JELLY EVERY 4th hrly
5. TAB: ND PAIN **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
6. SITZ BATH TWICE DAILY
7. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
8. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
9. TAB: MAXMALA 50 MG ONCE DAILY AT 8PM FOR 10 DAYS
10. TAB: ND Q10 ONCE DAILY AT 8PM FOR 10 DAYS

Review after 7 days in General Surgery OPD.

ARH1.0001230775		**Name**	Mrs. ISHRATH PARVEEN		
	Patient Identifier	ARHIP55689		**Age**	42Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	11-May-2022
	Date of Discharge				
	MLC No				
	Address	6-6-425, SHARMANAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, AWMI, SR

THROMBOLIZATION WITH INJ. TENETAPLACE (OUTSIDE)

SEVERE LV DYSFUNCTION [EF-35%]

CORONARY ANGIOGRAM DONE ON 16/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA DONE ON 16/05/2022
R/F : HTN

C/o chest pain, SOB with profuse sweating 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old female patient Mrs. ISHRATH PARVEEN came with c/o chest pain, SOB with profuse sweating 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, SR, THROMBOLIZATION WITH INJ. TENETAPLACE (OUTSIDE), SEVERE LV DYSFUNCTION [EF-35%], CORONARY ANGIOGRAM DONE ON 16/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 23 MM PRONOVA DONE ON 16/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. LOSAR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. BETALOC 25 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
8. TAB. THYRONORM 75 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230930		**Name**	Mrs. SAI ALLA LAXMI		
	Patient Identifier	ARHIP55734		**Age**	49Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	15-May-2022
	Date of Discharge				
	MLC No				
	Address	H.NO:10-25,CHIMALAPETA,JULAPALLY,PEDDAPALLY,Other,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 8
	Primary Consultant	Dr Chandra Shekar Sathineni			

ACUTE GASTROENTERITIS
URINARY TRACT INFECTION

C/o pain abdomen since 1 day associated with 3 episodes of vomitings

AT ADMISSION:

Afebrile

PR: 80/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 49 years old female patient Mrs. SAI ALLA LAXMI came with c/o pain abdomen since 1 day associated with 3 episodes of vomitings. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, URINARY TRACT INFECTION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. CALPOL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) TAB. PAN 40 MG ONCE DAILY AT 7AM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231074		**Name**	Mr. SRINVIAS RAO CHERUKURI
Patient Identifier	ARHIP55790	**Age**	52Yr 8Mth 10Days
Sex	Male	**Date of Admission**	19-May-2022
Date of Discharge			
MLC No			
Address	RAMNAGAR KMR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, SR, NO TLT

MODERATE LV SYSTOLIC DYSFUNCTION [EF-35%]

S/P: CORONARY ANGIOGRAM (23.05.2015) DONE OUTSIDE- Triple Vessel Disease (LAD Mid Total Occlusion, LCX-> Major OM - 80% Stenosis, RCA- Proximal - 90% Stenosis)

Primary PCI + Stents to Mid LAD (Xience- V 2.75 x 23 mm).

RCA (Xience Pro 3.5 x 28 mm)

Elective PTCA (25.05.2015) + Stent To LCX (Xience Xpedition 3.0 x 38 mm),

Atypical Chest Pain- Trop T Negative (29.07.2015)

Check- CAG (10.08.2015)

CORONARY ANGIOGRAM (19/05/2022) -CAD-TVD, MILD ISR IN LAD, LCX, RCA STENTS

PLAN MEDICAL MANAGEMENT FOR D2 (THIN VESSEL) OSTIAL DISEASE

R/F : HTN, T2DM

C/o Sudden onset chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. SRINVIAS RAO CHERUKURI came with c/o Sudden onset chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SR, NO TLT, MODERATE LV SYSTOLIC DYSFUNCTION [EF-35%], S/P: CORONARY ANGIOGRAM (23.05.2015) DONE OUTSIDE- Triple Vessel Disease (LAD Mid Total Occlusion, LCX-> Major OM - 80% Stenosis, RCA- Proximal - 90% Stenosis), Primary PCI + Stents to Mid LAD (Xience- V 2.75 x 23 mm), RCA (Xience Pro 3.5 x 28 mm), Elective PTCA (25.05.2015) + Stent To LCX (Xience Xpedition 3.0 x 38 mm), Atypical Chest Pain- Trop T Negative (29.07.2015), Check- CAG (10.08.2015), CORONARY ANGIOGRAM (19/05/2022) -CAD-TVD, MILD ISR IN LAD, LCX, RCA STENTS , PLAN MEDICAL MANAGEMENT FOR D2 (THIN VESSEL) OSTIAL DISEASE. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PROLOMET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.

5. TAB. COVANCE 25MG ONCE DAILY AT 8AM TO CONTINUE.

6. TAB. ANGISPAN TR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

7. TAB: VELOZ 20MG ONCE DAILY AT 8AM TO CONTINUE.

ADV: LIFE STYLE MODIFICATIONS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231024		**Name**	Mrs. B VIMALA		
	Patient Identifier	ARHIP55760		**Age**	56Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	17-May-2022
	Date of Discharge				
	MLC No				
	Address	katlakunta, jagityal,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 17/05/2022 – CAD-DVD (RCA, LAD)

PRIMARY PTCA+DES TO RCA WITH XIENCE XPEDITION 4.0 X 18 MM, LAD WITH XIENCE XPEDITION 3.0 X 15 MM DONE ON 17/05/2022

C/o chest pain since 1 day associated with shortness of breath

AT ADMISSION:

Patient is conscious and coherent
Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 56 years old female patient Mrs. B VIMALA came with c/o chest pain since 1 day associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 17/05/2022 – CAD-DVD (RCA, LAD), PRIMARY PTCA+DES TO RCA WITH XIENCE XPEDITION 4.0 X 18 MM, LAD WITH XIENCE XPEDITION 3.0 X 15 MM [LOT NO: 1062241, S/N :1070300-15], [LOT NO: 1032541, S/N : 1070400-18] DONE ON 17/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. PANTOCID 40MG ONCE DAILY AT 7AM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55763

ARH1.0001231025		**Name**	Mrs. M A BADRUNNISA		
	Patient Identifier	ARHIP55763		**Age**	67Yr 0Mth 0Days
	Sex	Female		**Date of Admission**	17-May-2022
	Expired Date	17-May-2022			
	MLC No				
	Address	ELLANTHAKUNTA,Karimnagar,Telangana		**Ward/Bed No**	First Floor, HDU, Bed no:HDU 11
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
A TYPICAL CHEST PAIN CORONARY ARETERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION CORONARY ANGIOGRAM AND PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASY TO D2 AND OM1 DONE ON 17/5/2022.	

ARH1.0001231025		**Name**	Mrs. M A BADRUNNISA		
Patient Identifier	ARHIP55763			**Age**	67Yr 0Mth 1Days
Sex	Female			**Date of Admission**	17-May-2022
Date of Discharge					
MLC No					
Address	ELLANTHAKUNTA,Karimnagar,Telangana			**Ward/Bed No**	First Floor, HDU, Bed no:HDU 11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY				

C/o chest pain since 1 day

AT ADMISSION:

PR: 90/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 67 years old female patient Mrs. M A BADRUNNISA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as A TYPICAL CHEST PAIN CORONARY ARETERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION CORONARY ANGIOGRAM AND PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASY TO D2 AND OM1 DONE ON 17/5/2022. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 09.15 PM on 17/05/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ATYPICAL CHEST PAIN, MYOCARDIAL INFARCTION

ARH1.0001230962		**Name**	Mr. K PRABHAKAR
Patient Identifier	ARHIP55747	**Age**	65Yr 0Mth 5Days
Sex	Male	**Date of Admission**	16-May-2022
Date of Discharge			
MLC No			
Address	Sulthanabad,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022
R/F: HTN, T2DM

C/o chest pain since few days

AT ADMISSION:

Afebrile

PR: 85/min

BP: 100/70 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 65 years old male patient Mr. PRABHAKAR came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230927		**Name**	Mr. GOPAL KISHAN RAO		
	Patient Identifier	ARHIP55733		**Age**	73Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	15-May-2022
	Date of Discharge				
	MLC No				
	Address	H.NO:118,BRAHMANDWADA (RAMNAGAR) TANDUR,MANCHIRIAL,Other,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 1
	Primary Consultant	Dr Chandra Shekar Sathineni			

UROSEPSIS
ALZHEIMER'S DISEASE
DIABETIC MELLITUS

C/o fever since 4 days associated with dysuria, burning micturition
Known case of Alzheimer's Disease

AT ADMISSION:

Afebrile

PR: 78/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 73 years old male patient Mr. GOPAL KISHAN RAO came with c/o fever since 4 days associated with dysuria, burning micturition. Known case of Alzheimer's Disease. All necessary investigations were done and diagnosed as UROSEPSIS, ALZHEIMER'S DISEASE, DIABETIC MELLITUS. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

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1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. RAZO-L ONCE DAILY AT 8AM FOR 10 DAYS

4) TAB. OXRA MET ONCE DAILY AT 2PM FOR 10 DAYS

5) INJ. TOUJEO 20 Units ONCE DAILY AT 8PM TO CONTINUE

6) TAB. GLUCO Q10 ONCE DAILY AT 2PM FOR 10 DAYS

7) TAB. ARVAST CV ONCE DAILY AT 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231131		**Name**	Mr. GUGGILLA LACHAIAH	
Patient Identifier	ARHIP55812	**Age**	69Yr 4Mth 1Days	
Sex	Male	**Date of Admission**	20-May-2022	
Date of Discharge	20-May-2022			
MLC No				
Address	21-73, RAMKISTAPUR,JAGTIAL,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 9	
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**		
Surgeons		**Anesthesiologists**		

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE NSTEMI, NO TLT SR, SEVERE LV SYSTOLIC DYSFUNCTION EF:30%. PLAN :CORONARY ANGIOGRAM	

C/o Chest pain since 20 days, difficulty in breathing

PHYSICAL EXAMINATION:

ON ADMISSION

Patient c/c

PR-131/min

BP-100/60mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-60% on 10 Litr O2

A 69 yrs old male patient GUGGILLA LACHAIAH came with c/o Chest pain since 20 days, difficulty in breathing. All necessary investigations done and diagnosed as CORONARY ARTERY DISEASE NSTEMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION EF:30%, PLAN :CORONARY ANGIOGRAM. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001204257		**Name**	Mrs. N PADMA
Patient Identifier	ARHIP55758	**Age**	50Yr 3Mth 21Days
Sex	Female	**Date of Admission**	17-May-2022
Date of Discharge			
MLC No			
Address	karimnagar,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

DRUG INDUCED HYPERKALEMIA

K/C/O DCMP

R/F : HTN, DM

REFER TO HIGHER CENTER

C/o chest pain on and off since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old female patient Mrs. N PADMA came with c/o chest pain on and off since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], DRUG INDUCED HYPERKALEMIA , K/C/O DCMP, R/F : HTN, DM , REFER TO HIGHER CENTER . Patient is referred to higher center for further management, hence patient is being discharged with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BISONEX 5 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. IVABRAD 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. ISOLANINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. INJ HUMAN MIXTURED 30/70 30 Units AT 8AM 15 Units AT 8PM CONTINUE
8. INJ LASIX 40 MG ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. SOBINIX 500 MG ONCE DAILY AT 2PM TO CONTINUE.
10. K-BIND SACHETS with glass of water 3rd hrly

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231071		**Name**	Mr. KHAZI MOHAMMADASHWAQ E ALI		
	Patient Identifier	ARHIP55787		**Age**	68Yr 4Mth 3Days
	Sex	Male		**Date of Admission**	18-May-2022
	Date of Discharge				
	MLC No				
	Address	5-4-191, KHAZI PURA,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022
R/F: T2DM

C/o chest pain since 2days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 68 years old male patient Mr. KHAZI MOHAMMADASHWAQE ALI came with c/o chest pain since 2days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001219310		**Name**	Mr. ODELU BANDARI
Patient Identifier	ARHIP55722	**Age**	61Yr 9Mth 11Days
Sex	Male	**Date of Admission**	14-May-2022
Date of Discharge			
MLC No			
Address	H.NO:14-4-506,VITAL NAGAR,GODHAVARIKHANI,PEDDAPALLY,Other,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ACUTE LVF

SEVERE LV SYSTOLIC DYSFUNCTION [EF-25%]

CORONARY ARTERY DISEASE

S/P CABG [2017]

EXTERNAL HAEMORRHOIDECTOMY [20/07/21]
DEBRIDEMENT WITH A HYSTEROSCOPY [20/01/22]
K/C/O ADHF

R/F : HTN, T2DM

C/o shortness of breath grade-IV associated with profuse sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 94/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 61 years old male patient Mr. ODELU BANDARI came with c/o shortness of breath grade-IV associated with profuse sweating since 1 day. All necessary investigations were done and diagnosed as ACUTE LVF, SEVERE LV SYSTOLIC DYSFUNCTION [EF-25%], CORONARY ARTERY DISEASE, S/P CABG [2017], EXTERNAL HAEMORRHOIDECTOMY [20/07/21], DEBRIDEMENT WITH A HYSTEROSCOPY [20/01/22], K/C/O ADHF, R/F : HTN, T2DM. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDIVAS 3.125MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB: FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
6. TAB: CIDMUS 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB: PYRIDIUM 200MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. HOME OXYGEN SUPPORT

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS, RFT REPORTS

ARH1.0001231018		**Name**	Mrs. RUKUM BAI DURGAM
Patient Identifier	ARHIP55768	**Age**	55Yr 0Mth 4Days
Sex	Female	**Date of Admission**	17-May-2022
Date of Discharge			
MLC No			
Address	POTHPALLE,Tandur,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

CORONARY ANGIOGRAM (21/05/2022) -CAD-SVD [LAD- Recanalized]

PLAN MEDICAL MANAGEMENT

C/o chest pain a/w mild SOB, sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. RUKUM BAI DURGAM came with c/o chest pain a/w mild SOB, sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], CORONARY ANGIOGRAM (21/05/2022) -CAD-SVD [LAD- Recanalized], PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231041		**Name**	Mr. TURKA PAPI REDDY ..
Patient Identifier	ARHIP55788	**Age**	40Yr 0Mth 3Days
Sex	Male	**Date of Admission**	18-May-2022
Date of Discharge			
MLC No			
Address	komatikondapur,jagityal,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 20
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ATYPICAL CHEST PAIN, LBBB, SR,
MODERATE LV SYSTOLIC DYSFUNCTION
R/F: HYPERTENSION
CORONARY ANGIOGRAM (21/05/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o chest pain, difficulty in breathing since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 40 years old male patient Mr. TURKA PAPI REDDY came with c/o chest pain, difficulty in breathing since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, LBBB, SR, MODERATE LV SYSTOLIC DYSFUNCTION, R/F: HYPERTENSION, CORONARY ANGIOGRAM (21/05/2022) -NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELMA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230962		**Name**	Mr. K PRABHAKAR		
	Patient Identifier	ARHIP55747		**Age**	65Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	16-May-2022
	Date of Discharge				
	MLC No				
	Address	Sulthanabad,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%

CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022
R/F: HTN, T2DM

C/o chest pain since few days

AT ADMISSION:

Afebrile

PR: 85/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. PRABHAKAR came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%, CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 32 MM METAFOR DONE ON 18/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. TELSAN 40 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. GLYCOMET SR 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

7) SYP. ASCORYL-D 2 tsp **THRICE IN A DAY AT 8 AM 2 PM 8 PM**

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231057		**Name**	Mrs. MANTHANI THARA		
	Patient Identifier	ARHIP55779		**Age**	51Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	18-May-2022
	Date of Discharge				
	MLC No				
	Address	7-93,MANTHANI,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU13
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE-ACUTE INFERIOR WALL MYOCARDIAL INFARCTION

NORMAL LV SYSTOLIC DYSFUNCTION EF:60%.

CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-TVD [LAD, LCX, RCA]

PRIMARY PTCA+DES TO RCA (2 STENTS) WITH 3V ASTRA 3.0 X 24 MM & METAFOR 4.0 X 16 MM DONE ON 18/05/2022
PLAN CABG LATER

R/F: HTN, T2DM

C/o chest pain a/w vomiting since 1 day

AT ADMISSION:

Afebrile

PR: 94/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 51 years old female patient Mrs. MANTHANI THARA came with c/o chest pain a/w vomiting since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NORMAL LV SYSTOLIC DYSFUNCTION EF:60%, CORONARY ANGIOGRAM DONE ON 18/05/2022 – CAD-TVD [LAD, LCX, RCA], PRIMARY PTCA+DES TO RCA (2 STENTS) WITH 3V ASTRA 3.0 X 24 MM & METAFOR 4.0 X 16 MM DONE ON 18/05/2022, PLAN CABG LATER, R/F: HTN, T2DM. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. GLYCOMET SR 500MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. METOLAR XT 25MG ONCE DAILY AT 8AM TO CONTINUE.

7)TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55667

LAXMINARSAVVA

ARH1.0001229629		**Name**	Mrs. LAXMI NARSAVVA KADAVA
Patient Identifier	ARHIP55663	**Age**	70Yr 1Mth 18Days
Sex	Female	**Date of Admission**	09-May-2022
Date of Discharge			
MLC No			
Address	NALLAGONDA, KODIMIAL,JAGITIAL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

SEVERE MR WITH MYXOMATOUS DEGENERATION OF MV LEAVLET
SURGERY: MVR WITH SJ NO. 27 MM, MECHANICAL VALVE DONE ON 17/05/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 70 years old female patient Mrs. LAXMINARSAVVA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as SEVERE MR WITH MYXOMATOUS DEGENERATION OF MV LEAVLET, SURGERY: MVR WITH SJ NO. 27 MM, MECHANICAL VALVE DONE ON 17/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, MILD LV DYSFUNCTION. NO CLOT/PE/VEG

BMI is 20.3 kg/m2.

Sr. Creatinine report done on 18.05.2022 1.0 mg/dl

DISCHARGE MEDICATION:

---

1) TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE FOR LIFE LONG.

2) TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE

4) TAB. COLPOL 500MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

6) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

55817

ARH1.0001222967		**Name**	Mrs. JAMEELA BEE		
	Patient Identifier	ARHIP55817		**Age**	64Yr 7Mth 3Days
	Sex	Female		**Date of Admission**	21-May-2022
	Date of Discharge				
	MLC No				
	Address	DHARUR, JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 1
	Primary Consultant	Dr Chandra Shekar Sathineni			

NEUROGLYCOPENIA,
ANEMIA,
DIABETIC MELLITUS

C/o unresponsiveness since 1 hour prior to arrival hospital

Known case of hypertension and diabetic mellitus

AT ADMISSION:

Patient is drowsy
PR: 80/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 64 years old female patient JAMEELA BEE came with c/o unresponsiveness since 1 hour prior to arrival hospital. Known case of hypertension and diabetic mellitus. All necessary investigations were done and diagnosed as NEUROGLYCOPENIA, ANEMIA, DIABETIC MELLITUS. Managed conservatively. 1 units of PCV transfusion given. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM FOR 5 DAYS

2) TAB. PROLOMET R ONCE DAILY AT 8AM FOR 5 DAYS

3) TAB. ECOSPRIN –AV 150/10 ONCE DAILY AT 2PM FOR 5 DAYS

4) TAB. GLUCO Q10 ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

[10:06 am, 23/05/2022] Dmo Sw: Guillain-Barre syndrome

Pt presented with weakness of bilateral upper and lower limbs LL>UL

Trunkal weakness , unable to roll on the bed,,

Not able to stand from squatting position

On examination pt had

Quadriparesis,

Bilateral deep tendon reflexes absent

Vitals -----.....

Pt presented with

All the necessary investigations were done

Nerve conduction studies were done which showed reduced Bilateral median and ulnar compound action potential and prolonged F wave latencies in Bilateral median, ulnar and Tibial nerves .... diagnosed as a case of

Guillain-Barré syndrome

Intravenous methylprednisolone was given along with other supportive measures and physiotherapy

Pt improved symptomatically, hence now pt is being discharged in a hemodynamically stable condition with all the required medications and advice

Review after 10 days

[10:11 am, 23/05/2022] Dmo Sw: Medicine tab gabantip at 300/10. Cap rejunex cd3 1od for 10 days.

ARH1.0001106205	ARHIP55767	Mrs. TURAGA HANMAVVA | Female | 75Yr 11Mth 25Days	**GW 5**	17-May-2022		Dr. SURESH GOUDS

5-94,PAIDIMADUGU,Karimnagar,Telangana

VESICAL CALCULUS

SURGERY: CYSTOLITHOTRIPSY DONE ON 19/05/2022

C/o pain abdomen associated with burning micturation

ON ADMISSION

Pt c/c/c

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

A 75 yrs old female patient Mrs. TURAGA HANMAVVA came to hospital with c/o pain abdomen associated with burning micturation . All necessary investigations done and diagnosed as VESICAL CALCULUS, SURGERY: CYSTOLITHOTRIPSY DONE ON 19/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40 MG ONCE DAILY AT 8AM FOR 11 DAYS.
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

APJ1.0001475650		**Name**	Mrs. KOMAMARAMMA CH
Patient Identifier	ARHIP55723	**Age**	70Yr 0Mth 18Days
Sex	Female	**Date of Admission**	14-May-2022
Date of Discharge			
MLC No			
Address	10-4-216, VAVILAPALLY,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:111 B
Primary Consultant	Dr Chandra Shekar Sathineni		

SEPSIS
ACUTE PULMONARY OEDEMA
DIABETES MELLITUS
CORONARY ARTERY DISEASE ON MEDICAL MANAGEMENT

C/o Shortness of breath grade III since 1 day associated with mild cough

AT ADMISSION:

Afebrile

PR: 94/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 23/min

SPO2: 98%

P/A: Soft

A 70 years old female patient Mrs. KOMAMARAMMA CH came with c/o Shortness of breath grade III since 1 day associated with mild cough. All necessary investigations were done and diagnosed as SEPSIS, ACUTE PULMONARY OEDEMA, DIABETES MELLITUS, CORONARY ARTERY DISEASE ON MEDICAL MANAGEMENT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) TAB. BILAHENZE M ONCE DAILY AT 8PM FOR 7 DAYS

5) TAB. DAPEFY 10 MG ONCE DAILY AT 2PM FOR 7 DAYS

6) TAB. LIPCURE GOLD ONCE DAILY AT 8PM FOR 7 DAYS

7) TAB. FRUSELAC DS ONCE DAILY AT 8PM FOR 7 DAYS

8) TAB. DILZEM 40 MG ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

55841

ARH1.0001231214		**Name**	Mr. KARUNAKAR POTHARAM		
	Patient Identifier	ARHIP55841		**Age**	68Yr 0Mth 0Days
	Sex	Male		**Date of Admission**	23-May-2022
	Date of Discharge				
	MLC No				
	Address	3-7-792, BANK COLONY,VAVILALAPALLY,Karimnagar,Telangana		**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE WITH UNSTABLE ANGINA WITH ECG CHANGES, MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%
VENTRICULAR BIGEMINY
R/F: T2DM, HTN
CORONARY ANGIOGRAM DONE ON 23/05/2022 – CAD-TVD [LAD, LCX, RCA]

ADV: CABG WITH GRAFT TO LAD, OM, DISTAL RCA

C/o Retrosternal chest pain, radiating to back since 10 days

At Admission

Afebrile

PR: 82/min

BP: 160/90 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 68 years old male patient Mr. KARUNAKAR POTHARAM came with c/o Retrosternal chest pain, radiating to back since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE WITH UNSTABLE ANGINA WITH ECG CHANGES, MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%
R/F: T2DM, HTN , VENTRICULAR BIGEMINY, CORONARY ANGIOGRAM DONE ON 23/05/2022 – CAD-TVD [LAD, LCX, RCA], ADV: CABG WITH GRAFT TO LAD, OM, DISTAL RCA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. CAP. CLOPITAB-A 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20 MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELDAY-H 80MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. DILNIP 10 MG ONCE DAILY AT 8PM TO CONTINUE.
5. CAP. METOLAR XR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. DIAMICRON XR 60 MG **TWICE IN A DAY AT 8 AM AND AT 8 PM** TO CONTINUE.
7. TAB. TAB VOBOSE M 0.3 MG **TWICE IN A DAY AT 8 AM AND AT 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001231028		**Name**	Mrs. MALLESWARI J		
	Patient Identifier	ARHIP55770		**Age**	55Yr 10Mth 23Days
	Sex	Female		**Date of Admission**	17-May-2022
	Date of Discharge				
	MLC No				
	Address	KATTARAMPUR D.NO 8-1-347 KMR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:103 B
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR			

GUILLAIN-BARRE SYNDROME

Patient presented with weakness of bilateral upper and lower limbs (LL>UL)

Trunkal weakness , unable to roll on the bed

Not able to stand from squatting position

AT ADMISSION:

O/E : Quadriparesis,

Bilateral deep tendon reflexes absent

PR: 76/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. MALLESWARI J came with c/o weakness of bilateral upper and lower limbs (LL>UL), Trunkal weakness , unable to roll on the bed, Not able to stand from squatting position, nerve conduction studies were done which showed reduced Bilateral median and ulnar compound action potential and prolonged F wave latencies in Bilateral median, ulnar and Tibial nerves, diagnosed as a case of Guillain-Barré syndrome. Intravenous methylprednisolone was given along with other

supportive measures and physiotherapy. Patient improved symptomatically, hence now patient is being discharged in a hemodynamically stable condition with all the required medications and advice.

DISCHARGE MEDICATION:

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1) TAB. GABANTIP 300 /10 MG ONCE DAILY AT 8PM FOR 10 DAYS

2) CAP. REJUNEX CD3 ONCE DAILY AT 8AM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN DR SANJAY KUMAR SIR OPD

APJ1.0016075026		**Name**	Mr. SYED SABIR PASHA		
	Patient Identifier	ARHIP55764		**Age**	63Yr 11Mth 7Days
	Sex	Male		**Date of Admission**	17-May-2022
	Date of Discharge				
	MLC No				
	Address	Q NO B-5/209, PTS NTPC,JYOTHI NAGAR, SOMANAPALLE,,Ramagundam,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:116 A
	Primary Consultant	Dr. RAMCHANDER TORREM			

CKD STAGE-5

IJV SEPSIS

CVA-INFARCT

DM/HTN/CAD

C/o SOB, vertigo, swelling of feet since 1 day

AT ADMISSION:

Afebrile

PR: 102/min

BP: 130/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

b/l pedal edema

A 63 years old male patient Mr. SYED SABIR PASHA came with c/o SOB, vertigo, swelling of feet since 1 day. All necessary investigations were done and diagnosed as CKD STAGE-5, IJV SEPSIS, CVA-INFARCT, DM/HTN/CAD. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. MHD (2/7)
2. TAB. SOBINIX DS ONCE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. ISOLAZINE **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
4. TAB. ROSAGOLD ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CARDIVAS 6.125 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. TAB. VELTAM 0.2 MG ONCE DAILY AT 8PM TO CONTINUE.
7. TAB. NICARDIA RETARD 10 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. NZCOQ10 ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. FEBGET 40 MG ONCE DAILY AT 8AM TO CONTINUE.
10. TAB. ENCORATE 300 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
11. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
12. TAB. DYTOR 20 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
13. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001230729		**Name**	Mr. DULAM MOGILI		
	Patient Identifier	ARHIP55657		**Age**	64Yr 5Mth 24Days
	Sex	Male		**Date of Admission**	09-May-2022
	Date of Discharge				
	MLC No				
	Address	Q.NO SB 150,RK 6 COLONY,SRIRAMPUR,MANCHERIAL-9949312780,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:106 B
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

RECURRENT CVA
DYSLIPIDAEMIA
HYPERTENSION
DEPRESSION

C/o slurring of speech since 1 day weakness of left upper limb and lower limb since 1 day
History of old CVA 1 year ago
Known case of hypertension since 10 years on treatment

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-72/min

BP-130/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-100%

A 64 yr old male patient Mr. DULAM MOGILI came with c/o slurring of speech since 1 day weakness of left upper limb and lower limb since 1 day, history of old CVA 1 year ago. Known case of hypertension since 10 years on treatment. All necessary investigations done and diagnosed as RECURRENT CVA, DYSLIPIDAEMIA , HYPERTENSION , DEPRESSION. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: ATORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: CLOPITAB 75 MG ONCE DAILY AT 2 PM TO CONTINUE
4. TAB. NICARDIA RETARD 20 MG ONCE IN A DAY AT 8 AM TO CONTINUE

Review after 7 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001222607		**Name**	Mrs. G LAXMI		
	Patient Identifier	ARHIP55759		**Age**	73Yr 9Mth 12Days
	Sex	Female		**Date of Admission**	17-May-2022
	Date of Discharge				
	MLC No				
	Address	4-100/31 VENKATESHWARACOLONY			

KARIMNAGAR

BILATERAL CEREBELLAR INFARCT
TYPE II DIABETIC MELLITUS
HYPERTENSION

C/o slurring of speech , giddiness and generalised weakness since 1 day

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-97/min

BP-130/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-99%

A 73 yr old female patient Mrs. G LAXMI came with c/o slurring of speech , giddiness and generalised weakness since 1 day. All necessary investigations done and diagnosed as BILATERAL CEREBELLAR INFARCT, TYPE II DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: ATORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: ZORYL-M2 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001231086		**Name**	Mr. SRINIVAS KOTA		
	Patient Identifier	ARHIP55797		**Age**	44Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	19-May-2022
	Date of Discharge				
	MLC No				
	Address	VIDYARANYAPURI, ROAD NO:1,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:108 A
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

ACUTE LEFT MCA INFARCT

C/o weakness of right upper limb and lower limb, giddiness since 1 day

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-130/80mmhg

RR-21/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 44 yr old male patient Mr. SRINIVAS KOTA came with c/o weakness of right upper limb and lower limb, giddiness since 1 day. All necessary investigations done and diagnosed as ACUTE LEFT MCA INFARCT. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: CLOPITAB 75 MG ONCE DAILY AT 2 PM TO CONTINUE
3. TAB: STORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
4. TAB: TRYCIT ONCE DAILY AT 8 AM TO CONTINUE

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001213822		**Name**	Mr. RAVINDER G		
	Patient Identifier	ARHIP55825		**Age**	52Yr 11Mth 11Days
	Sex	Male		**Date of Admission**	21-May-2022
	Date of Discharge				
	MLC No				
	Address	PRIME HOSPITAL 1 ST FLOR, SHARMANAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%]

OLD CAD, AWMI, POST PTCA DES TO LAD/OM DONE ON 05/06/21

R/F : HTN, T2DM

C/o chest pain burning type since 1 day associated with shortness of breath on exertion
History of bilateral pedal oedema +

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 74/min

BP: 120/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient RAVINDER came with c/o chest pain burning type since 1 day associated with shortness of breath on exertion, bilateral pedal oedema +. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%], OLD CAD, AWMI, POST PTCA DES TO LAD/OM DONE ON 05/06/21 . Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: TELMA 20MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLUCOMET GP 1/850 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231015		**Name**	Mr. RAJAIAH VODNALA		
	Patient Identifier	ARHIP55761		**Age**	72Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	17-May-2022
	Date of Discharge				
	MLC No				
	Address	WALLAMPAHAD,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 22
	Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch			

BENIGN PROSTATIC HYPERTROPHY
SURGERY: TRANSURETHRAL RESECTION OF THE PROSTATE DONE ON 19/05/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 60/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

All required investigations done and enclosed

A 72 yrs old male patient Mr. RAJAIAH VODNALA came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as BENIGN PROSTATIC HYPERTROPHY, SURGERY: TRANSURETHRAL RESECTION OF THE PROSTATE DONE ON 19/05/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP: CREMAFFIN 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO UROLOGY OPD

ARH1.0001231078		**Name**	Mrs. SAYILLA LAXMI
Patient Identifier	ARHIP55792	**Age**	49Yr 0Mth 4Days
Sex	Female	**Date of Admission**	19-May-2022
Date of Discharge			
MLC No			
Address	H.NO:10-25,CHEEMALAPET,JULAPALLY,PEDDAPALLY,Other,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 1
Primary Consultant	Dr. SURESH GOUD S(MS,		

LEFT URETERIC CALCULUS

SURGERY: LEFT URSL + DJ STENTING ON 20/05/2022

C/o abdominal pain, radiating to back a/w vomiting since 1 week.

ON ADMISSION

Patient c/c

Afebrile

PR-92/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 49 years old female patient Mrs. SAYILLA LAXMI presented to hospital with c/o abdominal pain, radiating to back a/w vomiting since 1 week. All necessary investigations were done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL + DJ STENTING ON 20/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001077815		**Name**	Mr. RAJAIAH RADHARAPU
Patient Identifier	ARHIP55818	**Age**	64Yr 2Mth 0Days
Sex	Male	**Date of Admission**	21-May-2022
Date of Discharge			
MLC No			
Address	THIRUMALNAGAR,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:122 A
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

LUMBAR SPONDYLOSIS
SUPRASPINATUS TENDINOPATHY
REFRACTORY PAIN

C/o chronic refractory backache

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-130/80mmhg

RR-21/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 64 yr old male patient Mr. RAJAIAH RADHARAPU came with c/o chronic refractory backache. All necessary investigations done and diagnosed as LUMBAR SPONDYLOSIS, SUPRASPINATUS TENDINOPATHY, REFRACTORY PAIN. Managed conservatively. Orthopaedic and Neurosurgeon consultations taken and advised followed. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: GABAPIN-NT 400/10 ONCE DAILY AT 8 PM TO CONTINUE
2. TAB: NEURIT CD3 ONCE DAILY AT 8 AM TO CONTINUE

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001231207	**Name**	Mrs. SALMA SULTANA			
	Patient Identifier	ARHIP55840		**Age**	58Yr 11Mth 8Days
	Sex	Female		**Date of Admission**	23-May-2022
	Date of Discharge				
	MLC No				
	Address	3-4-114 SAWARAN STREE,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 10
	Primary Consultant	DR. SRI KARAN UDDESH -- INTERNAL			

SMALL BOWEL OBSTRUCTION

C/o multiple episodes of vomitings, gastric region pain, body pains, mild vertigo and fever with chills since 1 day

AT ADMISSION:

PR: 97/min

BP: 150/90 mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 97%

P/A: Soft

A 58 years old female patient Mrs. SALMA SULTANA came with above mentioned complaints. Patient diagnosed as SMALL BOWEL OBSTRUCTION. Managed conservatively. General surgeon consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

DISCHARGE MEDICATION:

---

1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. METROGYL 400 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS

3) TAB. BUSCOPAN TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) SYP. SUCRAFIL-O 2tsp TWICE DAILY AT 8AM AND 8PM

5) TAB. SOMPRAZ-L TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

ADVICED TO CONSULT GENERAL SURGEON DR. GOUTHAM ROY

55736

ARH1.0001230851		**Name**	Mrs. LAXMI BHOND
Patient Identifier	ARHIP55736	**Age**	46Yr 0Mth 12Days
Sex	Female	**Date of Admission**	16-May-2022
Date of Discharge			
MLC No			
Address	KORUTLA,JAGTIAL,Other,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 2
Primary Consultant	Dr SOMASHEKAR K(MS		

Ss

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION + DM+HTN+S/P IWMI+OBESITY

SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 15/05/2022.

C/o chest pain, shortness of breath on exertion since 3 days

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 46 years old female patient Mrs. LAXMI BHOND came with c/o chest pain, shortness of breath on exertion since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION + DM+HTN+S/P IWMI+OBESITY, SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM,PDA] DONE ON 15/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC FUNCTION, GRADE-I DIASTOLIC DYSFUNCTION. NO PE/CLOT/VEG, EF-38%

BMI is 20.6 kg/m2.

Sr. Creatinine report on 16/05/2022 1.0 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROSAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

6) TAB. MET XL 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

7) TAB. METFORMIN 500 MG ONCE DAILY AT 8AM TO CONTINUE.

8) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

9) TAB. ROXSAFE CV 125+100 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

10) TAB. DOXY **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

11) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

12) TAB. ALPRAX 0.25 MG ONCE DAILY AT 7 PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

Lingia

ARH1.0001231202		**Name**	Mr. LINGAIAH CHILUMULA
Patient Identifier	ARHIP55839	**Age**	56Yr 0Mth 2Days
Sex	Male	**Date of Admission**	22-May-2022
Date of Discharge			
MLC No			
Address	15-3-653/1, LBNAGAR,PEDDAPALLI,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE , UNSTABLE ANGINA, SR

SEVERE LV SYSTOLIC DYSFUNCTION, [EF-30%]

POST PTCA DONE ON 2009 [LAD & RCA]

CORONARY ANGIOGRAM DONE ON 24/05/2022 – CAD-TVD [LAD, LCX, RCA]

PLAN CABG.

R/F DM, ALCOHOL, TOBACCO

C/o chest pain since a/w SOB since 10 days

At Admission

Afebrile

PR: 92/min

BP: 90/50 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 56 years old male patient Mr. LINGAIAH CHILUMULA came with c/o chest pain since a/w SOB since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , UNSTABLE ANGINA, SR, SEVERE LV SYSTOLIC DYSFUNCTION, [EF-30%], POST PTCA DONE ON 2009 [LAD & RCA], CORONARY ANGIOGRAM DONE ON 24/05/2022 – CAD-TVD [LAD, LCX, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. GLYCOMET-M 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001231258		**Name**	Mr. MD BABAR SHAREEF		
	Patient Identifier	ARHIP55859		**Age**	55Yr 0Mth 0Days
	Sex	Male		**Date of Admission**	24-May-2022
	Date of Discharge				
	MLC No				
	Address	korutla,jagityal,Karimnagar,Telangana		**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME 8
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

BREATHLESSNESS EVALUATION
GLOBAL HYPOKINESIA, MILD MR, MILD PAH, SR,
MODERATE LV SYSTOLIC DYSFUNCTION [EF- 35%]
R/F: HTN, SMOKING,
CKD
CORONARY ANGIOGRAM DONE ON 24.05.2022 -NORMAL CORONARIES [LEFT DOMINANT SYSTEM]
PLAN MEDICAL MANAGEMENT

C/o Shortness of breath on exertion, sweatings and dry cough since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 55 years old male patient Mr. MD BABAR SHAREEF came with c/o Shortness of breath on exertion, sweatings and dry cough since 1 day. All necessary investigations were done and diagnosed as BREATHLESSNESS EVALUATION, GLOBAL HYPOKINESIA, MILD MR, MILD PAH, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF- 35%], R/F: HTN, SMOKING, CKD, CORONARY ANGIOGRAM DONE ON 24.05.2022 -NORMAL CORONARIES [LEFT DOMINANT SYSTEM], PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. AZTOLET 10MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ISOLAZINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. DYTOR PLUS 10MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. MICINAC 600 MG WITH CUP OF WATER **TWICE IN A DAY AT 8 AM 8 PM** FOR 3 DAYS

NEPHROLOGIST TREATMENT TO CONTINUE

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001231196		**Name**	Mr. NARAHARI CHOUTAPELLY		
	Patient Identifier	ARHIP55835		**Age**	64Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	22-May-2022
	Date of Discharge				
	MLC No				
	Address	1-34, BALAPALLY,JAGTIAL,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 22/05/2022 – CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO LAD (Two stents) WITH 3.5 X 29 MM METAFOR TO PROXIMAL LAD, 3.0 X 24 MM METAFOR TO MID LAD DONE ON 22/05/2022
R/F: HTN, T2DM

C/o chest pain since 4-5 days

AT ADMISSION:

Afebrile

PR: 120/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 64 years old male patient Mr. NARAHARI CHOUTAPELLY came with c/o chest pain since 4-5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 22/05/2022 – CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO LAD (Two stents) WITH 3.5 X 29 MM METAFOR TO PROXIMAL LAD, 3.0 X 24 MM METAFOR TO MID LAD DONE ON 22/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) CAP. ABFLO 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. ZORYL M2 FORT 2MG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231335		**Name**	Mr. THIRUPATHI VADLAKONDA		
	Patient Identifier	ARHIP55869		**Age**	48Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	25-May-2022
	Date of Discharge				
	MLC No				
	Address	H.NO:1-4,BEEERSANI,BUGGARAM,JAGITIAL,Other,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 1
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY			

55882

ARH1.0001213822		**Name**	Mr. RAVINDER G
Patient Identifier	ARHIP55882	**Age**	52Yr 11Mth 14Days
Sex	Male	**Date of Admission**	26-May-2022
Date of Discharge			
MLC No			
Address	PRIME HOSPITAL 1 ST FLOR, SHARMANAGAR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI
MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%]
OLD CAD, AWMI, POST PTCA DES TO LAD/OM DONE ON 12/06/21
R/F : HTN, T2DM
CORONARY ANGIOGRAM DONE ON 26/05/2022 -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain burning type since 1 day associated with shortness of breath on exertion

History of bilateral pedal oedema +

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient RAVINDER came with c/o chest pain burning type since 1 day associated with shortness of breath on exertion, bilateral pedal oedema +. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MODERATE LV SYSTOLIC DYSFUNCTION [EF-37%], OLD CAD, AWMI, POST PTCA DES TO LAD/OM DONE ON 12/06/21 , R/F : HTN, T2DM, CORONARY ANGIOGRAM DONE ON 26/05/2022 -NORMAL CORONARIES , PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PROLOMET –XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB: TELMA 20MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. GLUCOMET GP 1/850 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS.

ARH1.0001230944		**Name**	Mrs. AFZAL BEGUM		
	Patient Identifier	ARHIP55737		**Age**	75Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	16-May-2022
	Expired Date	17-May-2022			
	MLC No				
	Address	kashmeergadda,Karimnagar,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 10
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
SEPTIC SHOCK.	Pd

History of fever, burning micturition since 4 days

Patient brought to ER in gasping state

AT ADMISSION:

Patient not responding to commands
PR: 97/min

BP: not recordable

RS: crackles +

CVS: S1S2

RR: 40/min

SPO2: 95%

P/A: Soft,

A 75 years old female patient Mrs. AFZAL BEGUM presented to hospital with above-mentioned complaints. Patient had VT , 150 J DC shock given, reverted to sinus rhythm, treated with inj. Amiodarone. Patient was intubated to mechanical ventilatorsupport on SIMV mode. CPR was initiated as per ACLS protocols, inspite of best effort return of spontaneous circulation could not be obtained, hence patient was declared as dead at 12.37am on 17/05/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEPTIC SHOCK SYNDROME.

55866

ARH1.0001231300		**Name**	Mrs. K BHUMAKKA		
	Patient Identifier	ARHIP55866		**Age**	65Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	24-May-2022
	Date of Discharge				
	MLC No				
	Address	DULLUR KORUTLA,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons				

ACUTE DECOMPENSATED HEART FAILURE

DCMP, LBBB, SEVERE MR, MILD PAH, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
DENOVO T2DM, HTN

C/o shortness of breath on exertion since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 22/min

SPO2: 92%

P/A: Soft

A 65 years old female patient Mrs. K BHUMAKKA came with c/o **shortness of breath on exertion since 1 day**. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, DCMP, LBBB, SEVERE MR, MILD PAH, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, DENOVO T2DM, HTN. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 10MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. ALDACTONE 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001227343		**Name**	Mr. RAJAMALLU T		
	Patient Identifier	ARHIP55843		**Age**	68Yr 3Mth 25Days
	Sex	Male		**Date of Admission**	23-May-2022
	Date of Discharge				
	MLC No				
	Address	SULTHANABAD,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 1
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

UNCONTROLLED TYPE II DIABETES MELLITUS
HYPOKALAEMIA

H/o Drowsiness since 1 day
H/o fever and weakness of left upper limb and lower limb

Known case of diabetes mellitus, CVA subacute SDH

AT ADMISSION:

Afebrile

PR: 76/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft, BS+

A 68 years old male patient Mr. RAJAMALLU T came with c/o drowsiness since 1 day, h/o fever and weakness of left upper limb and lower limb. All necessary investigations were done and diagnosed as UNCONTROLLED TYPE II DIABETES MELLITUS, HYPOKALAEMIA. Managed conservatively. General Physician consultation taken and advise followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. LEVERA 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) CAP. NEURIT CD3 ONCE DAILY AT 2PM FOR 7 DAYS

3) INJ HUMAN MIXTARD 30/70 12 Units AT 8AM 8 Units AT 8PM CONTINUE

4) SYP. DUPHALAC 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 7 DAYS IN DR NIKHIL SIR OPD

Pochamma 55864

CORROSIVE POISONING

Patient alleged to consume sanifresh (harpic) of approximately 50 mL quantity at her residence
C/o Severe abdominal pain, throat pain

AT ADMISSION:

Patient c/c

PR: 113/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 98%

P/A: Soft, BS+

A 30 years old female patient POCHAMMA came with h/o alleged to consume sanifresh (harpic) of approximately 50 mL quantity at her residence, c/o Severe abdominal pain, throat pain. All necessary investigations were done and diagnosed as CORROSIVE POISONING . Managed conservatively. Patient is referred to Higher Centre for Surgical Gastroenterologist for further management. Hence, patient is discharged at request.

ARH1.0001230872		**Name**	Mr. MYDAM VENKANNA
Patient Identifier	ARHIP55717	**Age**	62Yr 0Mth 14Days
Sex	Male	**Date of Admission**	13-May-2022
Date of Discharge			
MLC No			
Address	Jyothinagar Naspur,Mancherial,Telangana	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 12
Primary Consultant	DR. SRI KARAN UDDESH		

INTRACEREBRAL HAEMORRHAGE
AKI [PROBABLE CORTICAL NECROSIS]
RHABDOMYOLYSIS

C/o SOB grade-2 since 3 days, b/l pedal edema, decreased urine output

History of sudden onset proximal muscle weakness of lower limbs Was admitted at an outside hospital and was referred here in view of increased dyspnoea and creatine

Chronic alcoholic

AT ADMISSION:

Afebrile

PR: 78/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

CNS-B/l proximal muscle weakness of lower limbs, power 1/5

RR: 30/min

SPO2: 96% on room air

P/A: Soft,

A 62 years old male VENKANNA patient presented with the above-mentioned complaints as patient had bilateral lower limb weakness at admission an MRI of the spine was done which was normal. CPK was sent which was very high, in view of anuric AKI and CPK being high with proximal muscle weakness a diagnosis of rhabdomyolysis was made. Patient was started on haemodialysis on as needed basis. Patient was started on other supportive measures. During the hospital stay in the ICU patient suddenly developed right sided upper limb and lower limb weakness along with slurring of speech a CT brain revealed intracerebral haemorrhage. Neurosurgery and Neurophysician consultation was taken and patient was managed conservatively. Totally patient underwent 14 cycles of haemodialysis but patient still continued to have anuric AKI, so Nephrologist is suspecting probable cortical necrosis and renal biopsy was planned but as the patient is not stable to undergo renal biopsy procedure it has been deferred for now. Now the patient is being discharged in haemodynamically stable condition and will be requiring HEPARIN free dialysis thrice a week. He is being discharged with the following medication advice.

DISCHARGE MEDICATION:

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1) TAB. NODOSIS 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. ENCORODE 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

4) TAB. RENOSAVE TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

5) TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS

6) TAB. CUDCE FORT THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS

7) TAB. DEPIN RETARD 20 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

8) SYP. GLYCEROL 2tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM

9) SYP. DUPHALOC 10 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

55890

RTA POLYTRAUMA
MULTIPLE SMALL HAEMORRHAGIC CONTUSIONS
TRAUMATIC SAH
DIFFUSE AXONAL INJURY GRADE-I
FRACTURE RIGHT HUMERUS

Alleged to have sustained injury due to RTA Rolling of Car over the road on 26/05/22 around 3.30 pm sustained injury to right arm

Known case of hypothyroidism

AT ADMISSION:

Patient drowsy

Febrile -100 F

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft, BS+

GCS- E2,V3,M5, B/l PERL

A 59 years old female patient LAXMI REDDY came with Alleged to have sustained injury due to RTA Rolling of Car over the road on 26/05/22 around 3.30 pm sustained injury to right arm. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, MULTIPLE SMALL HAEMORRHAGIC CONTUSIONS, TRAUMATIC SAH, DIFFUSE AXONAL INJURY GRADE-I, FRACTURE RIGHT HUMERUS. Patient was hypotensive, ionotropic support given and now patient is haemodynamically stable. Patient's Hb was 7.7 mg/dl and 1 unit PRBC transfusion given. Patient's condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

Nagireddy tkr vr

Rajaiah dhs vr

ARH1.0001231422		**Name**	Mr. AKULA MOGILAIAH		
	Patient Identifier	ARHIP55895		**Age**	65Yr 0Mth 0Days
	Sex	Male		**Date of Admission**	27-May-2022
	Date of Discharge				
	MLC No				
	Address	PARKAL,Parkal,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

PERIOPERATIVE RISK EVALUATION
RWMA + MILD MR, SR
MILD LV SYSTOLIC DYSFUNCTION, (EF-50%)
CORONARY ANGIOGRAM DONE ON 27/05/2022- CAD- SVD LAD (D)
ADVISED MEDICAL MANAGEMENT (DIAGONAL THIN VESSEL)
PATIENT CAN UNDERGO NON-CARDIAC SURGERY UNDER MILD RISK

Patient came for preoperative risk evaluation for hernioplasty surgery

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old male patient Mr. AKULA MOGILAIAH came for preoperative risk evaluation for hernioplasty surgery. All necessary investigations were done and diagnosed as
PERIOPERATIVE RISK EVALUATION
RWMA + MILD MR, SR, MILD LV SYSTOLIC DYSFUNCTION, (EF-50%), CORONARY ANGIOGRAM DONE ON 27/05/2022- CAD- SVD LAD (D), ADVISED MEDICAL MANAGEMENT (DIAGONAL THIN VESSEL), PATIENT CAN UNDERGO NON-CARDIAC SURGERY UNDER MILD RISK.
Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001231140

Name	Mr. PUNNA BALAIAH		
Patient Identifier	ARHIP55816	**Age**	58Yr 0Mth 1Days
Sex	Male	**Date of Admission**	20-May-2022
Expired Date	21-May-2022		
MLC No			
Address	H.NO:9-2-207,BHAGATH NAGAR,Telangana	**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 7
Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	**Consultants**	
Surgeons	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN-- ANAESTHESIOLOGY

⊟ Cause of Death

Cause of Death

Diagnosis

Diagnosis

Disease	Disease Type
ROAD TRAFFIC ACCIDENT. LEFT FRONTO TEMPORO PARIETAL ACUTE SUBDURAL HAEMORRHAGE WITH MIDLINE SHIFT	

Alleged to have sustained injury due to slip and fall from two wheeler himself on 20/05/22
H/o LOC, ENT bleeding+

AT ADMISSION:

Patient unresponsive

PR: 124/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 97%

P/A: Soft

A 58 yrs old male patient Mr. PUNNA BALAIAH came to hospital with alleged to have sustained injury due to slip and fall from two wheeler himself on 20/05/22, h/o LOC, ENT bleeding+. All necessary investigations done and diagnosed as ROAD TRAFFIC ACCIDENT. LEFT FRONTO TEMPORO PARIETAL ACUTE SUBDURAL HAEMORRHAGE WITH MIDLINE SHIFT, SURGERY: LEFT FRONTO TEMPORO PARIETAL DECOMPRESSIVE CRANIECTOMY AND ACUTE SDH EVACUATION done on 21/05/2022. Post decompression surgery, patient was on ventilator (VC/AC mode) in view of low GCS. Poor prognosis explained to patient attendants. On 21.05.2022 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj.Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to normal sinus rhythm. Pupils dilated and fixed, Carotid

pulse not felt. 12 lead ECG showed asystole, hence declared dead at 4.50 AM on 21/05/2022.

CAUSE OF DEATH: CARDIO PULMONARY AREEST SECONDARY TO FRONTO PARIETAL ACUTE MASSIVE SUBDURAL HAEMORRHAGE

ARH1.0001231442		**Name**	Mrs. SARASWATHAMMA V
Patient Identifier	ARHIP55900	**Age**	80Yr 0Mth 1Days
Sex	Female	**Date of Admission**	27-May-2022
Date of Discharge			
MLC No			
Address	BALAJINAGAR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 6
Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY		

CLOSED HEAD INJURY

Alleged history of sustained injury due to slip and fall on 27/05/2022 around 5.30 pm at her home
History of 2 episodes vomitings +
Known case of hypertension on medication

AT ADMISSION:

Patient is drowsy

PR: 74/min

BP: 150/110mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft, BS+

GCS -E3, V4, M6

A 80yr old female patient Mrs. SARASWATHAMMA came to hospital with alleged history of sustained injury due to slip and fall on 27/05/2022 around 5.30 pm at her home, h/o 2 episodes vomitings +. All necessary investigations done and diagnosed as CLOSED HEAD INJURY . Conservative medical management given. Patient is being discharged in a hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: AUGMENTIN 625 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB. DOLO 650 TWICE DAILY AT 8AM, 8PM FOR 5DAYS.
3. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
4. TAB: PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 7 DAYS.
5. TAB. NAXDOM **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

Continue old hypertensive medications

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD.

ARH1.0001187329		**Name**	Mr. GUMMADI MALLAIAH
Patient Identifier	ARHIP55870	**Age**	72Yr 5Mth 24Days
Sex	Male	**Date of Admission**	25-May-2022
Date of Discharge			
MLC No			
Address	1-2-57,shashabmahal,near srinivasa theater,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE WMI, SR

NORMAL LV SYSTOLIC FUNCTION, EF-55%

R/F: HTN, T2DM

S/P LEFT PCNL (2007)

CORONARY ANGIOGRAM DONE ON 25/05/2022 – CAD-DVD (RCA, LAD)

PRIMARY PTCA+DES TO RCA, LAD WITH 3.5 X 38 MM XIENCE XPEDITION TO RCA, 3.5 X 28 MM XIENCE XPEDITION TO LAD DONE ON 25/05/2022

C/o chest pain a/w nausea, sweating since 2 days

AT ADMISSION:

Afebrile

PR: 92/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 72 years old male patient Mr. GUMMADI MALLAIAH came with c/o chest pain a/w nausea, sweating since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, R/F: HTN, T2DM, S/P LEFT PCNL (2007), CORONARY ANGIOGRAM DONE ON 25/05/2022 – CAD-DVD (RCA, LAD), PRIMARY PTCA+DES TO RCA, LAD WITH 3.5 X 38 MM XIENCE XPEDITION TO RCA, 3.5 X 28 MM XIENCE XPEDITION TO LAD DONE ON 25/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. VOBOSE-M 0.3/500 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. VELOZ 20 MG ONCE DAILY AT 8AM BEFORE BREAKFAST TO CONTINUE.

6) SYP. CREMAFFIN 10 ml ONCE DAILY AT 8 PM

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001139752		**Name**	Mr. VOLLALA RAMESH
Patient Identifier	ARHIP55874	**Age**	44Yr 11Mth 27Days
Sex	Male	**Date of Admission**	25-May-2022
Date of Discharge			
MLC No			
Address	T2-61, PH COLONY, GODAVARIKHANI, DIST: PEDDAPALLY,,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F: HTN, T2DM

CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-DVD (LAD & RCA)

PTCA+DES TO LAD WITH 3.0 X 28 MM BIOFREEDOM DONE ON 26/05/2022
MEDICAL MANAGEMENT FOR RCA

C/o chest pain since few days a/w sweating

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 44 years old male patient Mr. VOLLALA RAMESH came with c/o chest pain since few days a/w sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%, R/F: HTN, T2DM, CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-DVD (LAD & RCA), PTCA+DES TO LAD WITH 3.0 X 28 MM BIOFREEDOM DONE ON 26/05/2022, MEDICAL MANAGEMENT FOR RCA. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 7 DAYS

5) TAB. TENIVA-M ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. STARPRESS-R XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231358		**Name**	Mr. HARISHANKAR .		
	Patient Identifier	ARHIP55879		**Age**	41Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	26-May-2022
	Date of Discharge				
	MLC No				
	Address	1 GOPALPUR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

R/F: HTN, T2DM

CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-SVD (LCX)

PRIMARY PTCA+DES TO LCX WITH 2.5 X 13 MM METAFOR DONE ON 26/05/2022

C/o Retrosternal chest pain since 1 day associated with shortness of breath

AT ADMISSION:

Afebrile

PR:64/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 41 years old male patient Mr. HARISHANKAR came with c/o retrosternal chest pain since 1 day associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, R/F: HTN, T2DM , CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-SVD (LCX), PRIMARY PTCA+DES TO LCX WITH 2.5 X 13 MM METAFOR DONE ON 26/05/2022 . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231351		**Name**	Mr. YELLA REDDY SINGIREDDY
Patient Identifier	ARHIP55878	**Age**	42Yr 0Mth 3Days
Sex	Male	**Date of Admission**	25-May-2022
Date of Discharge			
MLC No			
Address	BOMMAREDDIPALLI,DHARMARAM,PEDDAPALLI,Other,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, EVOLVED ANTERIOR WALL MI, NO TLT

NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-DVD (RCA, LAD)

PTCA+DES TO LAD, RCA WITH 3.0 X 24 MM METAFOR TO LAD, 2.0 X 10 MM BALLOON TO RCA DONE ON 26/05/2022

C/o chest pain on and off since 10-15 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 42 years old male patient Mr. YELLA REDDY SINGIREDDY came with c/o chest pain on and off since 10-15 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, EVOLVED ANTERIOR WALL MI, NO TLT, NORMAL LV SYSTOLIC FUNCTION, EF-60%, R/F: HTN , CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-DVD (RCA, LAD), PTCA+DES TO LAD, RCA WITH 3.0 X 24 MM METAFOR TO LAD, 2.0 X 10 MM BALLOON TO RCA DONE ON 26/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. TIGATEL 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

5) TAB. PROLOMET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001169013		EDIT	**Name**	Mr. G BHARGAV YADHAV	
Patient Identifier	ARHIP55880		**Age**	56Yr 4Mth 29Days	
Sex	Male		**Date of Admission**	26-May-2022	
Date of Discharge					
MLC No					
Address	OBULAPUR MALLIAL JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3	
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY				

CORONARY ARTERY DISEASE, AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 16/10/2021 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52years old male patient Mr. GANDLA SHANKARAIAH came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MILD MR, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 16/10/2021 – CAD-SVD (LAD), Type-III vessel, proximal LAD significant stenisis. PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231348		**Name**	Mrs. N LAXMI		
	Patient Identifier	ARHIP55875		**Age**	60Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	25-May-2022
	Date of Discharge				
	MLC No				
	Address	MANKAMMATHOTA KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV SYSTOLIC FUNCTION, EF-55%

R/F: HTN, T2DM, HYPOTHYROIDISM

CORONARY ANGIOGRAM DONE ON 25/05/2022 – CAD-DVD (RCA, LCX)

PTCA+DES TO RCA, LCX (2 STENTS) RCA WITH 3.0 X 38 MM XIENCE XPEDITION, LCX WITH 3.0 X 23 MM XIENCE XPEDITION DONE ON 25/05/2022

C/o chest pain since 7 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. LAXMI came with c/o chest pain since 7 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV SYSTOLIC FUNCTION, EF-55%, R/F: HTN, T2DM, HYPOTHYROIDISM, CORONARY ANGIOGRAM DONE ON 25/05/2022 – CAD-DVD (RCA, LCX), PTCA+DES TO RCA, LCX (2 STENTS) RCA WITH 3.0 X 38 MM XIENCE XPEDITION, LCX WITH 3.0 X 23 MM XIENCE XPEDITION DONE ON 25/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. TELSAR 40MG ONCE DAILY AT 2PM TO CONTINUE.

5) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

6) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. STARPRESS XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

8) TAB. THYRORICH 150 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

APJ1.0002240508		**Name**	Mrs. MAHABOOB SULTANA		
	Patient Identifier	ARHIP55914		**Age**	81Yr 0Mth 25Days
	Sex	Female		**Date of Admission**	29-May-2022
	Date of Discharge				
	MLC No				
	Address	ZAREEN APARTMENTS DILSHAD NAGAR COLONY MEHDIPATNAM,Hyderabad,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 1
	Primary Consultant	Dr Chandra Shekar Sathineni(MD (In			

DIABETIC KETOACIDOSIS

Complaint of uncontrolled sugars evaluation

Known case of hypertension, diabetic mellitus and CVA

AT ADMISSION:

Afebrile

PR: 74/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft, BS+

A 81 years old female patient Mrs. MAHABOOB SULTANA came with c/o uncontrolled sugars evaluation. All necessary investigations were done and diagnosed as DIABETIC KETOACIDOSIS. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

---

1) TAB. STROCIT 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM FOR 7 DAYS

3) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 7 DAYS

4) TAB. ATORVA 40 MG ONCE DAILY AT 8PM FOR 7 DAYS

5) TAB. RAMIPRIL 2.5 MG ONCE DAILY AT 8AM FOR 7 DAYS

6) TAB. DAPAGLYN 10 MG ONCE DAILY AT 8AM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231191

Name	Mr. LAXMAIAH M		
Patient Identifier	ARHIP55832	**Age**	60Yr 0Mth 8Days
Sex	Male	**Date of Admission**	22-May-2022
Date of Discharge			
MLC No			
Address	3-92,DHARMAPURI , DONURU,JAGITYAL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 9
Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		

URINARY TRACT INFECTION [ESBL, Ecoli]
ALCOHOL WITHDRAWAL SYNDROME
RIGHT CLAVICLE FRACTURE
SEVERE HYPOKALAEMIA
HYPOMAGNESAEMIA

C/o fever since 3 days associated with burning micturition

History of fall from bed to 3 days back at home
History of Pain at right shoulder region

AT ADMISSION:

Patient c/c

Febrile- Temp 101 F

PR: 120/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 93%

P/A: Soft

A 60 years old male patient Mr. LAXMAIAH M presented with the above-mentioned complaints patient was diagnosed as urinary tract infection and alcohol withdrawal syndrome, patient was treated with antibiotics Benzodiazepines and patient had dyselectrolytemia and corrective measures were given for hypokalaemia and hypocalcaemia. Patient's cognition improved since admission but patient is still in alcohol withdrawal as attenders are unwilling for further patient is discharged against medical advice.

ARH1.0001231381		**Name**	Ms. SHANTHA G
Patient Identifier	ARHIP55883	**Age**	67Yr 0Mth 4Days
Sex	Female	**Date of Admission**	26-May-2022
Date of Discharge			
MLC No			
Address	VAVILALAPALLI, NEAR TEJA SCHOOL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 2.75 X 11 MM BIO FREEDOM DONE ON 26/05/2022
R/F: HTN, DM

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 93/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 67 years old female patient Ms. SHANTHA G came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 26/05/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 2.75 X 11 MM BIO FREEDOM [LOT NO: W21100017, S/N :210909929] DONE ON 26/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

4) CAP. BEVON ONCE DAILY AT 2PM TO CONTINUE.

5) TAB. AZULIX-2 ONCE DAILY AT 7AM BEFORE BREAKFAST TO CONTINUE.

6) TAB. SGLTR ONCE DAILY AT 2PM BEFORE LUNCH TO CONTINUE.

7) TAB. VELOZ 20 MG ONCE DAILY AT 7AM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231440		**Name**	Mrs. SAMALLA MUTHAMMA		
	Patient Identifier	ARHIP55898		**Age**	72Yr 8Mth 3Days
	Sex	Female		**Date of Admission**	27-May-2022
	Date of Discharge				
	MLC No				
	Address	5-4-63, AMBEDKAR ROAD,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 30/05/2022 – CAD-DVD [LAD, RCA]

PLAN CABG.

C/o Retrosternal chest pain a/w SOB since 10 days

At Admission

Afebrile

PR: 62/min

BP: 130/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 72 years old female patient Mrs. SAMALLA MUTHAMMA came with c/o retrosternal chest pain a/w SOB since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 30/05/2022 – CAD-DVD [LAD, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RAMISTAR 1.25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

PRP

ARH1.0001231426		**Name**	Mr. BOJJA RAJA MOULI		
	Patient Identifier	ARHIP55893		**Age**	70Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	27-May-2022
	Date of Discharge	30-May-2022			
	MLC No				
	Address	KISAN NAGAR,Karimnagar,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 4
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
SEPSIS(LRTI), AKI, PARAPLEGIA,PROBABLE MULTIPLE MYELOMA	

C/o left sided chest pain 15 days ago
H/o Progressive dyspnoea since 15 days
H/o Altered sensorium
H/o Urinary incontinence

Known case of hypertension

AT ADMISSION:

Patient tachypnoeic , in altered sensorium
PR: 109/min

BP: 90/60mmHg

RS: BAE+ [Bilateral wheeze, Bilateral crackles +]
CNS - bilateral lower limbs power 0/5
Tone-Hypotonia

Plantar-Mute

CVS: S1S2

RR: 20/min

SPO2: 91% on room air

P/A: Soft,

A 70 years old male Mr. BOJJA RAJA MOULI patient presented with above-mentioned complaints, on initial examination patient had bilateral lower limb weakness with power 0 /5 with paralysis, patient has had altered sensorium and labor to breathing. Patient was started on nebulisation and antibiotics. MRI spine and MRI brain were done, reports awaited, films were attached with summary. USG abdomen was done, which showed presence of right renal simple cortical cyst, cholelithiasis, bilateral grade-I renal parenchymal changes, Neurosurgeon and neurophysician consultations were taken and advices were followed. On day 2 of hospitalisation patient clinically improved and his sensorium was improved. On day 4 of hospitalisation patient saturation were suddenly dropped and became tachypnoeic, hence he was connected to NIV. Patient needs further hospitalisation and risk were explained, but patient attenders are willing to go another Hospital. Hence patient is being discharged against medical advice

ARH1.0001231335		**Name**	Mr. THIRUPATHI VADLAKONDA
Patient Identifier	ARHIP55869	**Age**	48Yr 0Mth 6Days
Sex	Male	**Date of Admission**	25-May-2022
Date of Discharge			
MLC No			
Address	H.NO:1-4,BEEERSANI,BUGGARAM,JAGITIAL,Other,Telangana	**Ward/Bed No**	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,MCH		

CORONARY ARTERY DISEASE+LMCA 100% BLOCK + MODERATE LV DYSFUNCTION +S/P AWMI

SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, LIMA TO LAD] FOR LMCA DONE ON 25/05/2022.

C/o retrosternal chest pain a/w sweating since 1 day

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 48 years old male patient Mr. THIRUPATHI VADLAKONDA presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+LMCA 100% BLOCK + MODERATE LV DYSFUNCTION +S/P AWMI, SURGERY – EMERGENCY CORONARY ARTERY BYPASS GRAFTING FOR

LMCA DONE ON 25/05/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC DYSFUNCTION, NO PE/CLOT/VEG

BMI is 21.1 kg/m2.

Sr. Creatinine report on 26.05.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET-A [75+150] ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. MET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. IVERZAC 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

9) TAB. CALPOL 500MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001231490		**Name**	Mr. GOPAL SALLURI
Patient Identifier	ARHIP55923	**Age**	42Yr 1Mth 25Days
Sex	Male	**Date of Admission**	30-May-2022
Date of Discharge			
MLC No			
Address	KMR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 5
Primary Consultant	DR. SUBRAT KUMAR SOREN --NEUROSURGERY		

RTA
CLOSED HEAD INJURY

Alleged history of RTA 2Wheeler vs 2 Wheeler at 9.40 pm near Kataram and sustained injury to head and left shoulder

History of ear and nosebleed represent

AT ADMISSION:

PR: 110/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 22/min

SPO2: 97%

P/A: Soft

GCS-15/15

A 42 years old male patient Mr. GOPAL SALLURI came with alleged history of RTA 2Wheeler vs 2 Wheeler at 9.40 pm near Kataram and sustained injury to head and left shoulder, history of ear and nosebleed represent. All necessary investigations were done and diagnosed as RTA, CLOSED HEAD INJURY. Managed conservatively. Orthopaedic consultation taken and advised followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2. TAB. NAXDOM 250 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

3. TAB. PANTOP 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.

4. TAB. AUGMENTIN 625 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

5. TAB. TOLPERITES-D **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

6. SOFT CERVICAL COLLAR FOR 7 DAYS

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD

55911 v rajaiah

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MIOCARDIAL INFARCTION, SR

NORMAL LV SYSTOLIC FUNCTION, EF-54%

R/F: HTN, CHRONIC SMOKER

CORONARY ANGIOGRAM DONE ON 29/05/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.0 X 37 MM METAFOR DONE ON 29/05/2022

C/o Retrosternal chest pain a/w mild sweating since 1 day

AT ADMISSION:

Afebrile

PR: 75/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. V RAJAIAH came with c/o Retrosternal chest pain a/w mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MIOCARDIAL INFARCTION, SR, NORMAL LV SYSTOLIC FUNCTION, EF-54%, R/F: HTN, CHRONIC SMOKER, CORONARY ANGIOGRAM DONE ON 29/05/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.0 X 37 MM METAFOR [LOT NO: MG80, S/N :CM37MG80008] DONE ON 29/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

5) TAB. PROLOMET R 25MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231536		**Name**	Mr. MARK AJAY		
	Patient Identifier	ARHIP55938		**Age**	32Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	31-May-2022
	Date of Discharge				
	MLC No				
	Address	ANNAPURNA COLONY , PEDDAPALLY,Ramagundam,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 9
	Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY		**Consultants**	
	Surgeons			**Anesthesiologists**	

RTA
TRAUMATIC BAIN INJURY
ACUTE SDH & TRAUMATIC SAH
MULTIPLE HAEMORRHAGIC CONTUSIONS
FRACTURE BONE 5TH METAPHALYNGEAL LEFT

Alleged history of RTA 2Wheeler vs 2 Wheeler at 8.30 pm on 30/05/2022 near Peddapally and sustained injury to head, left hand and left lower limb

AT ADMISSION:

PR: 110/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft

GCS-E2, V3, M5

A 32 years old male patient Mr. MARK AJAY came with alleged history of RTA 2Wheeler vs 2 Wheeler at 8.30 pm on 30/05/2022 near Peddapally and sustained injury to head, left hand and left lower limb. All necessary investigations were done and diagnosed as RTA, TRAUMATIC BAIN INJURY, ACUTE SDH & TRAUMATIC SAH, MULTIPLE HAEMORRHAGIC CONTUSIONS, FRACTURE BONE 5TH METAPHALYNGEAL LEFT. Orthopaedic consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001231488		**Name**	Mr. M SAMPATH KUMAR		
	Patient Identifier	ARHIP55921		**Age**	28Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	30-May-2022
	Date of Discharge				
	MLC No				
	Address	GALIPELLY,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

CORONARY ANGIOGRAM (31/05/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain a/w SOB, sweatings since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 28 years old male patient Mr. M SAMPATH KUMAR came with c/o chest pain a/w SOB, sweatings since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], CORONARY ANGIOGRAM (31/05/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231569		**Name**	Mr. B LAXMAIAH	
Patient Identifier	ARHIP55953		**Age**	65Yr 0Mth 1Days
Sex	Male		**Date of Admission**	01-Jun-2022
Date of Discharge	01-Jun-2022			
MLC No				
Address	KARIMNAGAR,Karimnagar,Telangana		**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME4
Primary Consultant	DR. SANJAY KUMAR KAMINWAR(MD,DM(Neurology),Consultant Neuro Physician)--NEUROLOGY		**Consultants**	
Surgeons			**Anesthesiologi**	

sts

Diagnosis

Diagnosis

Disease	Disease Type
CVA -ACUTE LEFT MCA INFARCT THROBOLISED WITH TPA (TENECTASE)WITH ACUTE RE INFARCT IN LEFT MCA.	

C/o Sudden onset weakness of right upper limb, facial deviation to right

AT ADMISSION:

Afebrile

PR: 98/min

BP: 190/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft,

A 65 years old male patient Mr. LAXMAIAH came with c/o sudden onset weakness of right upper limb, facial deviation to right. All necessary investigations were done and diagnosed as CVA -ACUTE LEFT MCA INFARCT THROBOLISED WITH TPA (TENECTASE)WITH ACUTE RE INFARCT IN LEFT MCA. Thrombolised with INJ. TENECTASE 14 mg IV slowly over 1 minute, power of 5 /5 developed in right side after 5 minutes of thrombolisation. After 3 hours power again deteriorated to upper limb 0/ 5 and lower limb 1 /5 of right side. Post thrombolysis MRI done suggestive of acute left MCA territory infarct (ischaemic on etiology) . Patient attendants requested for discharge, patient referred to Higher Centre for further management.

ARH1.0001231478		**Name**	Mr. THULALA RAVI
Patient Identifier	ARHIP55915	**Age**	37Yr 0Mth 2Days
Sex	Male	**Date of Admission**	29-May-2022
Expired Date	31-May-2022		
MLC No			
Address	velgatoor,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
AKI WITH VIRAL FEVER WITH SEPTIC SHOCK	

C/o severe SOB since 3 days

AT ADMISSION:

PR: 110/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 98%

P/A: Soft

A 37 years old male patient Mr. THULALA RAVI came with c/o severe SOB since 3 days. All necessary investigations were done and diagnosed as AKI WITH VIRAL FEVER WITH SEPTIC SHOCK. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs

guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 09.15 AM on 29/05/2022.

CAUSE OF DEATH

AKI WITH VIRAL FEVER WITH SEPTIC SHOCK

ARH1.0001231439		**Name**	Mrs. KOTHAPELLY PADMA		
	Patient Identifier	ARHIP55926		**Age**	42Yr 0Mth 5Days
	Sex	Female		**Date of Admission**	30-May-2022
	Date of Discharge				
	MLC No				
	Address	1-1,GOLLAPALLI,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU11
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

CORONARY ANGIOGRAM (01/06/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 42 years old female patient Mrs. KOTHAPELLY PADMA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], CORONARY ANGIOGRAM (01/06/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ANGISPAN-TR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. TELMA-CT 40/6.25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CILACAR 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. ENCORATE 200 MG ONCE DAILY AT 8PM TO CONTINUE.
8. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231104		**Name**	Mr. G VAMSHI
Patient Identifier	ARHIP55803	**Age**	25Yr 0Mth 14Days
Sex	Male	**Date of Admission**	20-May-2022
Date of Discharge			
MLC No			

Address	THOMBARAOPET JAGITIAL,Karimnagar,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 3
Primary Consultant	DR. SUBRAT KUMAR SOREN --NEUROSURGERY	**Consultants**	
Surgeons	DR. SUBRAT KUMAR SOREN --NEUROSURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP55803	ARH1.000123110

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
	21			

ROAD TRAFFIC ACCIDENT, SEVERE HEAD INJURY

DIFFUSE AXONAL INJURY [GRADE II-III]

ACUTE EDH (SMALL) ON RIGHT FRONTAL REGION

ACUTE THIN SDH LEFT TEMPORAL REGION

MULTIPLE HAEMORRHAGIC CONTUSIONS LEFT TEMPORAL LOBE

DIFFUSE CEREBRAL EDEMA WITH LEFT LATERAL VENTRICLE EFFACEMENT

POST TRAUMATIC DELAYED SEIZURE

RIGHT HEMIPARESIS

S/P: LEFT FTP DECOMPRESSIVE CRANIECTOMY DONE ON 21/05/2022

Alleged history of RTA 2Wheeler vs 2 Wheeler around 7.00 pm on 19/05/2022 and sustained injury to head.
History of LOC+, initially treated at outside hospital and came here for further management

AT ADMISSION:

Patient is drowsy

PR: 113/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 32/min

SPO2: 97%

P/A: Soft

GCS-E2,V5,M6

TREATMENT GIVEN:

Injectable antiepileptic, antibiotics (Meropenem, Linezolid) antiedema measures, analgesics and other supportive treatment given

A 25 years old male patient Mr. G VAMSHI came with alleged history of RTA 2Wheeler vs 2 Wheeler around 7.00 pm on 19/05/2022 and sustained injury to head, history of LOC+, Initially treated at outside hospital and came here for further management. All necessary investigations were done and diagnosed as ROAD TRAFFIC ACCIDENT, SEVERE HEAD INJURY, DIFFUSE AXONAL INJURY [GRADE II-III], ACUTE EDH (SMALL) ON RIGHT FRONTAL REGION, ACUTE THIN SDH LEFT TEMPORAL REGION, MULTIPLE HAEMORRHAGIC CONTUSIONS LEFT TEMPORAL LOBE, DIFFUSE CEREBRAL EDEMA WITH LEFT LATERAL VENTRICLE EFFACEMENT, POST TRAUMATIC DELAYED SEIZURE, RIGHT HEMIPARESIS, S/P: LEFT FTP DECOMPRESSIVE CRANIECTOMY DONE ON 21/05/2022. Postoperative period was uneventful. Patient developed fever, empirical appropriate antibiotics given. Now patient is haemodynamically stable, Afebrile, no evidence of active seizure, SPO2 maintained at room air. GCS-E2 V3 M5, pupil-b/l reacting to light. Patient attendants explained regarding further Neurorehabilitation, travel risk and associated further deterioration. Hence patient is being discharged.

ARH1.0001231402	**Name**	Mr. K MONDAIAH	
Patient Identifier	ARHIP55958	**Age**	43Yr 0Mth 7Days
Sex	Male	**Date of Admission**	01-Jun-2022
Date of Discharge			
MLC No			
Address	BUGGARAM, JAGITYAL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION, EF-60%

S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-LM

PLAN CABG.

C/o chest pain since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 43 years old male patient Mr. K MONDAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%, S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-LM, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. NOVASTAT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001087117		**Name**	Mr. ANNADI SANJEEVA REDDY
Patient Identifier	ARHIP55936	**Age**	80Yr 9Mth 26Days
Sex	Male	**Date of Admission**	31-May-2022
Expired Date	01-Jun-2022		
MLC No			
Address	SHATHRAJ PALLI,VEMULAWADA,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 3
Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Consultant Nephrologist)--NEPHROLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type

ACUTE ON CKD, SEPTIC SHOCK

ARH1.0001231570

Name	Mr. ABHIRAM B		
Patient Identifier	ARHIP55955	**Age**	24Yr 0Mth 1Days
Sex	Male	**Date of Admission**	01-Jun-2022
Date of Discharge			
MLC No			
Address	POOSALA ROAD, SULTHANABAD, KARIMNAGAR,Telangana	**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 4
Primary Consultant	Dr. GOUTHAM ROY (MS		

GALLSTONE DISEASE
SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.06.2022

C/o abdomen distension, nausea, discomfortness in abdomen since 5 days
H/o Appendicitis in 2012

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 24 yr old male patient ABHIRAM came with c/o abdomen distension, nausea, discomfortness in abdomen since 5 days. All necessary investigations done and diagnosed as GALLSTONE DISEASE, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.06.2022. Findings: Well distended gallbladder with well defined calot's. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.

4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS

5. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001231475		**Name**	Mr. GAFFAR MD
Patient Identifier	ARHIP55912	**Age**	34Yr 0Mth 4Days
Sex	Male	**Date of Admission**	29-May-2022
Date of Discharge			
MLC No			
Address	KMR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

TLT DONE OUT SIDE WITH INJ. TENECTEPLASE

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

CORONARY ANGIOGRAM (01/06/2022) -CAD-SVD (proximal LAD ecatic-Recanalised)

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 34 years old male patient Mr. GAFFAR MD came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, TLT DONE OUT SIDE WITH INJ. TENECTEPLASE, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], CORONARY ANGIOGRAM (01/06/2022) -CAD-SVD (proximal LAD ecatic-Recanalised), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231554		**Name**	Mrs. AMISHETTI VENKATAMMA
Patient Identifier	ARHIP55946	**Age**	56Yr 4Mth 2Days
Sex	Female	**Date of Admission**	31-May-2022
Date of Discharge			
MLC No			
Address	2-20/A, THEEGALAGUTTAPALLY,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-LM+TVD, [LAD, RCA, LCX]

PLAN CABG.

R/F HTN, DM

C/o chest pain since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 56 years old female patient Mrs. AMISHETTI VENKATAMMA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-LM+TVD, [LAD, RCA, LCX], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. METOLAR-XR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001010608		**Name**	Mr. J RAGHUPATHI
Patient Identifier	ARHIP55957	**Age**	64Yr 9Mth 29Days
Sex	Male	**Date of Admission**	01-Jun-2022
Date of Discharge			
MLC No			
Address	4-73/8 SARASWATHI NGAR THEEGALAGUTTAPALLI,Karimnagar,Andhra Pradesh	**Ward/Bed No**	First Floor, CICU , Bed no:CICU13
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION, EF-55%

S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-SVD-[LAD]

PLAN CABG.

R/F HTN, HYPOTHYROID

K/C/O THROMBOCYTOPENIA

C/o chest pain since 4-5 days a/w SOB, generalized weakness

At Admission

Afebrile

PR: 82/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 64 years old male patient RAGHUPATHI came with c/o chest pain since 4-5 days a/w SOB, generalized weakness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, S/P CORONARY ANGIOGRAM DONE ON 01/06/2022 – CAD-SVD-[LAD], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. NOVASTAT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TIGATEL 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MONIT-GTN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. THYRONORM 150 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC

M SAI NATH 32 55966

CHIN LACERATION SECONDARY TO RTA
SURGERY: SUTURING OF CHIN LACERATION DONE ON 02.06.2022

Alleged history of RTA 2 Wheeler versus 4 Wheeler on 01/06/2022 at 5 pm
History of right Ear bleed +

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-94/min

BP-130/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-99%

A 32 yrs old male patient SAINATH came with alleged history of RTA 2 Wheeler versus 4 Wheeler on 01/06/2022 at 5 pm, history of right Ear bleed +. All necessary investigations done and diagnosed as CHIN LACERATION SECONDARY TO RTA, SURGERY: SUTURING OF CHIN LACERATION DONE ON 02.06.2022. Findings: Laceration measuring 4 x 2 cm noted in the lower level of chin. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.

3. TAB: ROTAVAULT THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS.

4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.

5. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

6. T-BACT OINTMENT FOR L/A

Review after 7 days in General Surgery OPD.

55918

ARH1.0001218477		**Name**	Mrs. LAXMI P		
	Patient Identifier	ARHIP55918		**Age**	86Yr 5Mth 2Days
	Sex	Female		**Date of Admission**	29-May-2022
	Date of Discharge				
	MLC No				
	Address	NTPC,JYOTHINAGAR,,Ramagundam,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, AWMI, NO TLT, SR

SEVERE LV DYSFUNCTION [EF-30%]

S/P RIGHT FEMUR NAILING (2021)

RIGHT IT FRACTURE

R/F : HTN

C/o chest pain a/w SOB grade-3 since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 92% on room air

P/A: Soft

A 86 years old female patient P. LAXMI came with c/o chest pain a/w SOB grade-3 since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, NO TLT, SR, SEVERE LV DYSFUNCTION [EF-30%], S/P RIGHT FEMUR NAILING (2021), RIGHT IT FRACTURE. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 9PM TO CONTINUE.
4. TAB. CONCOR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. DYTOR PLUS LS ONCE DAILY AT 8AM TO CONTINUE.
7. TAB: NEXPRO 20MG ONCE DAILY AT 7AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001230273	**Name**	Mr. LACHAIAH AMSHALA		
	Patient Identifier	ARHIP55932	**Age**	47Yr 1Mth 9Days
	Sex	Male	**Date of Admission**	30-May-2022
	Date of Discharge			
	MLC No			
	Address	MALLAPUR,DHARMARAM,Other,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 28/04/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA DONE ON 31/05/2022

C/o chest pain since 1 month

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 47years old male patient Mr. LACHAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 28/04/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA [LOT NO: 220940028011A, S/N :20096281006] DONE ON 31/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASITA UDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231550		**Name**	Mr. GANGADHARA MALLESHAM		
	Patient Identifier	ARHIP55941		**Age**	46Yr 1Mth 2Days
	Sex	Male		**Date of Admission**	31-May-2022
	Date of Discharge				
	MLC No				
	Address	7-12,SRIRAMULAPALLI,KODIMIAL,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE LATERAL WALL MI, NO TLT, SR

MILD LV DYSFUNCTION, EF-47%

CORONARY ANGIOGRAM DONE ON 31/05/2022 – CAD-DVD (LAD, LCX)

PRIMARY ANGIOPLASTY TO OM1 & D1 [THROMBUS ASPIRATION] DONE, TIMI III FLOW ACHIEVED ON 31/05/2022

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 46years old male patient Mr. GANGADHARA MALLESHAM came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE LATERAL WALL MI, NO TLT, SR, MILD LV DYSFUNCTION, EF-47%, CORONARY ANGIOGRAM DONE ON 31/05/2022 – CAD-DVD (LAD, LCX), PRIMARY ANGIOPLASTY TO OM1 & D1 [THROMBUS ASPIRATION] DONE, TIMI III FLOW ACHIEVED ON 31/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. BRILINTA 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ROSUVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230273	**Name**	Mr. LACHAIAH AMSHALA			
	Patient Identifier	ARHIP55932		**Age**	47Yr 1Mth 9Days
	Sex	Male		**Date of Admission**	30-May-2022
	Date of Discharge				
	MLC No				
	Address	MALLAPUR,DHARMARAM,Other,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 28/04/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA DONE ON 31/05/2022

C/o chest pain since 1 month

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 47years old male patient Mr. LACHAIAH came with c/o chest pain since 1 month. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 28/04/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 4.0 X 28 MM 3V ASTRA [LOT NO: 220940028011A, S/N :20096281006] DONE ON 31/05/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. BETALOC 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. FRUSELOC ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

7) TAB. FEBUTAZ 40 MG ONCE DAILY AT 2PM FOR 7 DAYS

8) TAB. GOUTNIL 0.5 MG ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001224965		**Name**	Mr. S VENKATAIAH
Patient Identifier	ARHIP55979	**Age**	86Yr 5Mth 30Days
Sex	Male	**Date of Admission**	02-Jun-2022
Date of Discharge			
MLC No			
Address	ALGUNOOR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 12
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

S

HYPOGLYCEMIA, SEIZURES DISORDER
K/C/O HYPERTENSION, TYPE II DIABETES MELLITUS

C/o gradual decrease of level of consciousness since 1 day

AT ADMISSION:

Afebrile

PR: 94/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 95%

P/A: Soft

A 86 years old male patient Mr. VENKATAIAH came with c/o gradual decrease of level of consciousness since 1 day. All necessary investigations were done and diagnosed as HYPOGLYCEMIA, SEIZURES DISORDER, K/C/O HYPERTENSION, TYPE II DIABETES MELLITUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB: TELMA-AM ONCE DAILY AT 8AM TO CONTINUE

2. TAB: SPINFREE 25MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE

3. TAB: LEVIPIL 500MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE

REVIEW AFTER 7 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001231640	**Name**	Mr. B KANAKAIAH	
Patient Identifier	ARHIP55971	**Age**	64Yr 0Mth 1Days
Sex	Male	**Date of Admission**	02-Jun-2022
Date of Discharge			
MLC No			
Address	GODAVARIKHANI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

CORONARY ANGIOGRAM (02/06/2022) -CAD-Mild disease

PLAN MEDICAL MANAGEMENT

R/F : HTN, HYPOTHYROID

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 64 years old male patient KANAKAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NORMAL LV SYSTOLIC FUNCTION [EF-60%], CORONARY ANGIOGRAM (02/06/2022) -CAD-Mild disease, PLAN MEDICAL MANAGEMENT. General Physician Consultation taken and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. NOVASTAT 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. NEXPRO 40MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. THYRONORM 200MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD WITH FT4, TSH, Anti TPO antibodies reports

ARH1.0001231559		**Name**	Mrs. ANKAM SAROJANA		
	Patient Identifier	ARHIP55949		**Age**	49Yr 3Mth 0Days
	Sex	Female		**Date of Admission**	31-May-2022
	Date of Discharge				
	MLC No				
	Address	17-23/A, MANTHANI,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU11
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CRHD

SEVERE MITRAL STENOSIS [EF-60%]

CORONARY ANGIOGRAM (02/06/2022) -NORMAL CORONARIES

PLAN FOR MVR

C/o palpitations a/w grade-2 SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 49 years old female patient Mrs. ANKAM SAROJANA came with c/o palpitations a/w grade-2 SOB since 1 day. All necessary investigations were done and diagnosed as CRHD, SEVERE MITRAL STENOSIS [EF-60%], CORONARY ANGIOGRAM (02/06/2022) - NORMAL CORONARIES, PLAN FOR MVR. CTVS consultation taken and advised MVR. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. MET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. LANOXIN 0.25MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231622		**Name**	Mr. MANOHARN
Patient Identifier	ARHIP55975	**Age**	50Yr 0Mth 2Days
Sex	Male	**Date of Admission**	02-Jun-2022
Date of Discharge			
MLC No			
Address	SARASWATHINAGAR, ROAD NO:3,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:120 A
Primary Consultant	Dr Chandra Shekar Sathineni(		

ACUTE GASTROENTERITIS
DIABETES MELLITUS

C/o loose motions, vomitings since 2 days

AT ADMISSION:

Afebrile

PR: 87/min

BP: 100/60 mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. MANOHAR N came with c/o loose motions, vomitings since 2 days. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, DIABETES MELLITUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. INJ. HUMAN MIXTARD 30 /70 40 UNITS AT 8AM, 20 UNITS AT 8 PM TO CONTINUE
2. TAB. ARVAST-CV ONCE DAILY AT 8 PM FOR 10 DAYS
3. TAB. GLUCO-Q10 ONCE DAILY AT 2 PM FOR 10 DAYS
4. TAB. RAZO-L ONCE DAILY AT 8 AM FOR 15 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001227237		**Name**	Mr. MOHAMMAD ISMAIL BAIG .
Patient Identifier	ARHIP55928	**Age**	65Yr 4Mth 5Days
Sex	Male	**Date of Admission**	30-May-2022
Date of Discharge			
MLC No			
Address	HOUSE NO: 5-5-108 STREET: GUNJ STREET DISTRICT: JAGTIAL,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:118 C
Primary Consultant	Dr. SURESH GOUD S(MS		

PROSTATOMEGALY + STRICTURE URETHRA
SURGERY: TURP + OPTICAL URETHRATOMY DONE ON 31/05/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 65 yrs old male patient Mr. MOHAMMAD ISMAIL BAIG came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as PROSTATOMEGALY + STRICTURE URETHRA, SURGERY: TURP + OPTICAL URETHRATOMY DONE ON 31/05/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP: K-CIT 10 ml TWICE DAILY AT 8AM, 8PM

REVIEW AFTER 11 DAYS TO UROLOGY OPD

ARH1.0001208211		**Name**	Mr. GOLLA RAVI
Patient Identifier	ARHIP55969	**Age**	44Yr 5Mth 3Days
Sex	Male	**Date of Admission**	02-Jun-2022
Date of Discharge			
MLC No			
Address	7-4-321,KASHMEERGADDA,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 5
Primary Consultant	Dr. GOUTHAM ROY (MS		

GRADE-IV INTERNAL HEMORRHOIDS
SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 02/06/2022

C/o per rectum bleeding, mild constipation since 3 months

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 44 yrs old male patient Mr. GOLLA RAVI came with c/o per rectum bleeding, mild constipation since 3 months. All necessary investigations done and diagnosed as GRADE-IV INTERNAL HEMORRHOIDS, SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 02/06/2022. Findings: Multiple internal hemorrhoids noted in the anal canal @ 3'O, 7'O & 4'O clock in position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. GLUTAVAULT –V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4th hrly
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM

Review after 7 days in General Surgery OPD.

ARH1.0001231676	**Name**	Mr. L DHAMODHAR	
Patient Identifier	ARHIP55992	**Age**	72Yr 0Mth 1Days
Sex	Male	**Date of Admission**	04-Jun-2022
Date of Discharge			
MLC No			
Address	peddapally,Karimnagar,Telangana	**Ward/Bed No**	First Floor, HDU, Bed no:HDU 2
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY	**Consultants**	
Surgeons			

PRE-SYNCOPE

History of slip and fall from chair
Loss of consciousness multiple episodes of vomiting, ENT bleed
Fever since 1 day

Known case of mentally retarded

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/50 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 72 years old male patient Mr. DHAMODHAR came with history of slip and fall from chair, Loss of consciousness multiple episodes of vomiting, ENT bleed, Fever since 1 day. Known case of mentally retarded. All necessary investigations were done and diagnosed as PRE-SYNCOPE. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

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1. TAB. ENCORATE CHRONO 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
2. TAB. NEXITO PLUS ONCE **IN A DAY AT 8 PM** FOR 7 DAYS
3. CAP. CARNIK-LC ONCE **IN A DAY AT 8 AM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001231421		**Name**	Mr. MARAMPELLI NADPIGANGARAM		
	Patient Identifier	ARHIP55963		**Age**	61Yr 4Mth 8Days
	Sex	Male		**Date of Admission**	01-Jun-2022
	Date of Discharge				
	MLC No				
	Address	1-75/1, CHINTHAKUNTA,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE,

NON ST ELEVATION MYOCARDIAL INFARCTION

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (04/06/2022) -CAD-RCA mild disease

PLAN MEDICAL MANAGEMENT

C/o chest pain, breathlessness since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old male patient Mr. MARAMPELLI NADPIGANGARAM came with c/o chest pain, breathlessness since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATION MYOCARDIAL INFARCTION, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (04/06/2022) -CAD-RCA mild disease, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NOVASTAT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. ANGISPAN TR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. RAMISTAR 1.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231521	**Name**	Mr. NILAM RAJU	
Patient Identifier	ARHIP55927	**Age**	27Yr 4Mth 5Days
Sex	Male	**Date of Admission**	30-May-2022
Date of Discharge			
MLC No			
Address	2-61, SIRIKONDA,Sircilla,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 2
Primary Consultant	Dr. SURESH GOUD S(MS,M		

LEFT PROXIMAL URETERIC CALCULUS
SURGERY : LEFT PUSH BACK PCNL AND DJ STENTING DONE ON 31.05.2022

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 27 yrs old male patient Mr. NILAM RAJU came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT PROXIMAL URETERIC CALCULUS, SURGERY : LEFT PUSH BACK PCNL AND DJ STENTING DONE ON 31.05.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001106670		**Name**	Mr. CH NARSAIAH		
	Patient Identifier	ARHIP55950		**Age**	61Yr 11Mth 29Days
	Sex	Male		**Date of Admission**	31-May-2022
	Date of Discharge				
	MLC No				
	Address	vegurupally manakonduru,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 3
	Primary Consultant	Dr. SURESH GOUD			

LEFT URETERIC CALCULUS

SURGERY: LEFT URSL + DJ STENTING ON 01/06/2022

C/o left loin pain, burning micturition since 1 week.

ON ADMISSION

Patient c/c

Afebrile

PR-92/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 61 years old male patient Mr. NARSAIAH presented to hospital with c/o left loin pain, burning micturition since 1 week. All necessary investigations were done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL + DJ STENTING ON 01/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001231566	**Name**	Mrs. B BAKKAVVA	
Patient Identifier	ARHIP55952	**Age**	41Yr 0Mth 4Days
Sex	Female	**Date of Admission**	01-Jun-2022
Date of Discharge			
MLC No			
Address	malkapelly, kasheepet, mancheryal,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 5
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (01/06/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

R/F : Br. ASTHMA

C/o chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 41 years old female patient BAKKAVVA came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SF, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (01/06/2022) -CAD-NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPIDOGREL 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. CAP. ABFLO 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. CAP. AMPOXIN THRICE **IN A DAY AT 8 AM 2PM AND 8 PM** FOR 3 DAYS
6. FOROCORT 200 INHALER 1 puff TWICE DAILY AT 8AM 8PM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231580		**Name**	Mr. JANGA HARITHA		
	Patient Identifier	ARHIP55960		**Age**	18Yr 5Mth 3Days
	Sex	Male		**Date of Admission**	01-Jun-2022
	Date of Discharge				
	MLC No				
	Address	2-72/3, GADDAPAKA,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 14
	Primary Consultant	Dr. RAMCHANDER TORREM(			

NEPHROTIC SYNDROME

C/o Shortness of breath, bilateral pedal oedema

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 18 years old male patient Mr. JANGA HARITHA came with c/o shortness of breath, bilateral pedal oedema. All necessary investigations were done and diagnosed as NEPHROTIC SYNDROME. Renal biopsy done under aseptic conditions, procedure was uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. CEFARAZ-CV TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. SYP. TUSQ 2 tsp TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001231527		**Name**	Mr. SUDHEER KALLEPALLY
Patient Identifier	ARHIP55929	**Age**	40Yr 0Mth 5Days
Sex	Male	**Date of Admission**	30-May-2022
Date of Discharge			
MLC No			
Address	1-84,paddapalli,karimnagr,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:118 A
Primary Consultant	Dr. RAMCHANDER TORREM		

RAPIDLY PROGRESSIVE RENAL FAILURE

DIABETES MELLITUS
HYPERTENSION

C/o generalized weakness, fever, dysuria and shortness of breath, giddiness since 2 days

AT ADMISSION:

Afebrile

PR: 74/min

BP: 150/110mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old male patient SUDHEER KALLEPALLY came with c/o generalized weakness, fever, dysuria and shortness of breath, giddiness since 2 days. All necessary investigations were done and diagnosed as RAPIDLY PROGRESSIVE RENAL FAILURE, DIABETES MELLITUS, HYPERTENSION. Renal biopsy done under aseptic conditions, procedure was uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. CEFARAZ-CV 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. METOZ 5 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CARDIVAS 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. GEROZ-LP **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
7. TAB. MOXOVAS 0.3 MG **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** FOR 7 DAYS.
8. TAB. MINIPRESS-XL **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
10. TAB. ZOFER 4 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
11. INJ HUMAN MIXTARD 30/70 15 Units AT 8AM 12 Units AT 8PM CONTINUE

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001207837		**Name**	Mr. ITIKYALA BALAIAH
Patient Identifier	ARHIP55930	**Age**	63Yr 5Mth 3Days
Sex	Male	**Date of Admission**	30-May-2022
Date of Discharge			
MLC No			
Address	1-89/1,SHIVAJI WADA,RAIKAL,JAGTIAL,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:118 B
Primary Consultant	Dr. RAMCHANDER TORREM(MD		

AKI

DIABETES MELLITUS
HYPERTENSION

C/o generalized weakness, fever since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old male patient Mr. ITIKYALA BALAIAH came with c/o generalized weakness, fever since 2 days. All necessary investigations were done and diagnosed as AKI, DIABETES MELLITUS, HYPERTENSION. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. FAROALFA 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
2. TAB. SOBINIX-DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. RECLIDE-XR 30 MG ½ TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. STORVAS 40 MG ONCE DAILY AT 8PM TO CONTINUE.
7. TAB. ISOLAZINE 20+375 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. METOCARD XL 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. SYP. UROFIT 1 tsp **TWICE IN A DAY AT 8 AM 8 PM**
10. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
11. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001209631		**Name**	Mr. PRANEETH KUMAR CH		
	Patient Identifier	ARHIP56021		**Age**	31Yr 1Mth 6Days
	Sex	Male		**Date of Admission**	06-Jun-2022
	Date of Discharge	06-Jun-2022			
	MLC No				
	Address	VIDYANAGAR,,Karimnagar,Telangana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

ATYPICAL CHEST PAIN, TMT POSITIVE SR, NORMAL LV SYSTOLIC FUNCTION
K/C/O SVT,
R/F SMOKING
CORONARY AGIOGRAM DONE 6/6/2022 NORMAL CORONARIES (LEFT DOMINANT SYSTEM)
ADV;MEDICAL MANAGEMENT

C/o palpitations on and off since few days, pain radiating to left arm

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 31 years old male patient Mr. PRANEETH KUMAR CH came with c/o palpitations on and off since few days, pain radiating to left arm. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, TMT POSITIVE SR, NORMAL LV SYSTOLIC FUNCTION, K/C/O SVT, R/F SMOKING, CORONARY AGIOGRAM DONE 6/6/2022 NORMAL CORONARIES (LEFT DOMINANT SYSTEM), ADV;MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. CAP. ECOSPRIN GOLD 10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. CALAPTIN SR 120 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. NEXPRO 40 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001231202		**Name**	Mr. LINGAIAH CHILUMULA		
	Patient Identifier	ARHIP55867		**Age**	56Yr 0Mth 16Days
	Sex	Male		**Date of Admission**	25-May-2022
	Date of Discharge				
	MLC No				
	Address	15-3-653/1, LBNAGAR,PEDDAPALLI,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 4
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(			

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P AWMI+DM+HTN, S/P ISR OF RCA & LAD

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 02/06/2022.

C/o retrosternal chest pain a/w sweating since 3 days

K/c/o HTN, T2DM

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 56 years old male patient Mr. LINGAIAH CHILUMULA presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P AWMI+DM+HTN, S/P ISR OF RCA & LAD, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 02/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC FUNCTION, MILD/PR/TR/PAH, EF-34% NO PE/CLOT/VEG.

BMI is 21 kg/m2.

Sr. Creatinine report on 03.06.2022 0.8 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. PROLOMET 25 MG TWICE DAILY AT 8AM 8PM BBF TO CONTINUE.

4) TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM BBF TO CONTINUE.

5) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

7) TAB. GLIMESTAR-M4 ONCE DAILY AT 8AM TO CONTINUE.

8) TAB. ZITAMET PLUS ONCE DAILY AT 8AM TO CONTINUE.

9) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

10) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

11) TAB. DOLO 650MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001231746		**Name**	Mr. RAVULA PRAVEEN
Patient Identifier	ARHIP56008	**Age**	46Yr 0Mth 2Days
Sex	Male	**Date of Admission**	05-Jun-2022
Date of Discharge			
MLC No			
Address	6-41/2,Iqbal ahmed nagar, mancherial,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 05/06/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 23 MM XIENCE XPEDITION DONE ON 05/06/2022
R/F: T2DM

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. RAVULA PRAVEEN came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 05/06/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 23 MM XIENCE XPEDITION DONE ON 05/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. NOVASTAT 40MG ONCE DAILY AT 8AM TO CONTINUE.

4) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. VOGLIVOSE 0.2 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. GLUCORED ½ TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231792

Name	Mrs. MEDAM SUNITHA		
Patient Identifier	ARHIP56033	**Age**	39Yr 0Mth 1Days
Sex	Female	**Date of Admission**	07-Jun-2022
Date of Discharge	07-Jun-2022		
MLC No			
Address	q no : sd-27,naspur colony,,Mancherial,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 10
Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
SEPSIS WITH MODS.	Pd

C/o Shortness of breath since 3 days
Sudden onset of severe hypoxia and restlessness since 1 day treated outside hospital and came here for further management

History of 1 episode of GTCS with the tongue bite

AT ADMISSION:

Patient mechanical ventilator

PR: 86/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 39 years old female patient Mrs. MEDAM SUNITHA came with above mentioned complaints. Patient diagnosed as SEPSIS WITH MODS. Patient treated with Inj Levipil, Inj Piptaz, Inj Vit.K, Inj Albumin, Inj Zofer and Pan, Nebulization. Patient condition improved. Patient is being discharged in hemodynamically stable condition.

ARH1.0001231477		**Name**	Mrs. BHUMAMMA ADIKOPPULA
Patient Identifier	ARHIP55916	**Age**	47Yr 0Mth 10Days
Sex	Female	**Date of Admission**	29-May-2022
Date of Discharge			
MLC No			
Address	H.NO:1-82,PEDAGAPALLE,KALWASRIRAMPUR,PEDDAPALLY,Other,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 3
Primary Consultant	DR. SANJAY KUMAR KAMINWAR		

LEFT BASAL GANGLIA BLEED
OLD LACUNAR INFARCT IN PONS
OLD POST CRANIOTOMY STATUS (JAN 2020)

C/o weakness of right upper limb and lower limb
History of left decompressive craniectomy for IC bleed in 2020

AT ADMISSION:

Afebrile

PR: 84/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft, BS+

A 47 years old female patient Mrs. BHUMAMMA ADIKOPPULA came with c/o weakness of right upper limb and lower limb, history of left decompressive craniectomy for IC bleed in 2020. All necessary investigations were done and diagnosed as LEFT BASAL GANGLIA BLEED , OLD LACUNAR INFARCT IN PONS, OLD POST CRANIOTOMY STATUS (JAN 2020). Managed conservatively. 2D echo showed RWMA cardiologist consultation taken and advised coronary angiogram later, antiplatelets not given because of bleeding. Neurosurgeon consultation taken and advised followed . Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. TAZLOC 40 MG ONCE DAILY AT 2PM FOR 7 DAYS

3) TAB. TONACT 20 MG ONCE DAILY AT 8PM FOR 7 DAYS

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS

5) TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 10 DAYS IN DR SANJAY KUMAR SIR OPD

ARH1.0001087117		**Name**	Mr. ANNADI SANJEEVA REDDY
Patient Identifier	ARHIP55936	**Age**	80Yr 9Mth 26Days
Sex	Male	**Date of Admission**	31-May-2022
Expired Date	01-Jun-2022		
MLC No			
Address	SHATHRAJ PALLI,VEMULAWADA,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 3
Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Consultant Nephrologist)--NEPHROLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

ACUTE ON CKD, SEPTIC SHOCK

Patient brought to Emergency Room with SOB a/w b/l pedal edema, abdominal distension

AT ADMISSION:

PR: 60/min

BP: 100/60 mmHg

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft, BS+

A 80 years old male patient Mr. ANNADI SANJEEVA REDDY patient brought to Emergency Room with SOB a/w b/l pedal edema, abdominal distension, Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, continued for 5 cycles but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 05.51 pm on 31/05/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO ACUTE ON CKD, SEPTIC SHOCK

ARH1.0001231675	**Name**	Mr. SAMBAIAH V			
	Patient Identifier	ARHIP55989		**Age**	72Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	03-Jun-2022
	Date of Discharge				
	MLC No				
	Address	4-73/8/8/ C,HANUMANNAGAR,KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:119 B
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR			

CVA- ACUTE ISCHAEMIC STROKE

History of giddiness since 4 days, vomiting 1 episode

Known case of hypertension, diabetes mellitus

AT ADMISSION:

Afebrile

PR: 83/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 72 years old male patient V SAMBAIAH came with c/o giddiness since 4 days, vomiting 1 episode, Known case of hypertension, diabetes mellitus. All necessary investigations were done and diagnosed as CVA- ACUTE ISCHAEMIC STROKE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. PREVA-AS 75 MG ONCE DAILY AT 2PM FOR 5 DAYS

2) TAB. COLTRO 10 MG ONCE DAILY AT 2PM FOR 5 DAYS

3) TAB. SPINFREE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN DR SANJAY KUMAR SIR OPD

ARH1.0001231732	**Name**	Mrs. SHAKUNTHALA MEDI			
	Patient Identifier	ARHIP56003		**Age**	56Yr 11Mth 7Days
	Sex	Female		**Date of Admission**	05-Jun-2022
	Date of Discharge				
	MLC No				
	Address	4-330,LAXMIDEVIPALLE,GANGADHARA,KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:108 A
	Primary Consultant	DR. SRI KARAN UDDESH			

PROBABLE TRANSIENT ISCHAEMIC ATTACK
HYPOTHYROIDISM

C/o headache, nausea, transient blurring of vision 2 episodes

Known case of hypothyroidism

AT ADMISSION:

Afebrile

PR: 64/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99% on room air

P/A: Soft

A 56 years old female patient SHAKUNTHALA came with above mentioned complaints. Patient diagnosed as PROBABLE TRANSIENT ISCHAEMIC ATTACK, HYPOTHYROIDISM. Managed conservatively. Neurophysician consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET-A 75/75 MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

3) TAB. CHYMORAL FORTE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 3 DAYS

4) SYP. LACTIFIBER 15 ml TWICE DAILY AT 8AM AND 8PM

5) CONTINUE HYPOTHYROID MEDICATION

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

56015

ARH1.0001231756		**Name**	Mrs. VANI LAMBU
Patient Identifier	ARHIP56015	**Age**	45Yr 0Mth 2Days
Sex	Female	**Date of Admission**	06-Jun-2022
Date of Discharge			
MLC No			
Address	VIDYAARANYAPURI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 6
Primary Consultant	Dr. GOUTHAM ROY (		

EXTERNO-INTERNAL HEMORRHOIDS
SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 07/06/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 45 yrs old female patient Mrs. VANI LAMBU came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as EXTERNO-INTERNAL HEMORRHOIDS
SURGERY: OPEN HEMORRHOIDECTOMY DONE ON 07/06/2022. Findings: External hemorrhoids at 11'O clock and 3'O clock internal haemorrhoids noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: BECOSULES ONCE DAILY AT 2PM FOR 15 DAYS.
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. TAB: ND PAIN **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
4. GLUTAVAULT –V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
5. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
6. XYLOCAINE JELLY EVERY 4th hrly
7. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
8. SITZ BATH **TWICE IN A DAY AT 8 AM 8 PM**

Review after 7 days in General Surgery OPD.

ARH1.0001231775		**Name**	Mr. SHREYANSH M		
	Patient Identifier	ARHIP56034		**Age**	6Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	07-Jun-2022
	Date of Discharge				
	MLC No				
	Address	13-111,NEAR OLD POST OFFICE,GUEST HOUSE ROAD,DHARMAPURI,Other,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:120A
	Primary Consultant	Dr. GOUTHAM ROY (			

PREPEUCAL SKIN TRAUMA WITH LACERATION

SURGERY: CIRCUMCISSION DONE ON 07/06/2022

C/o laceration over the prepuce skin secondary to trauma

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-90/min

BP-100/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 06 yrs old male Mr. SHREYANSH came with c/o laceration over the prepuce skin secondary to trauma. All necessary investigations done and diagnosed as PREPEUCAL SKIN TRAUMA WITH LACERATION,
SURGERY: CIRCUMCISSION DONE ON 07/06/2022. Findings: Deep laceration in the prepuce skin. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. SYP. AUGMENTIN 475 MG 5 ml TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. SYP. RANTAC 3 ml TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. SYP. IBUGESIC PLUS 3 ml TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
4. T-BACT OINTMENT FOR L/A

Review after 7 days in General Surgery OPD.

ARH1.0001231760		**Name**	Mr. ARELLI KISTA SWAMY		
	Patient Identifier	ARHIP56019		**Age**	62Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	06-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Vittal nagar Godavarikhani,Ramagundam,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:123 A
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

TYPE II DIABETES MELLITUS
TRANSIENT ISCHAEMIC ATTACK

History of right sided numbness, paraesthesia since few days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. ARELLI KISTA SWAMY came with c/o right sided numbness, paraesthesia since few days. All necessary investigations were done and diagnosed as TYPE II DIABETES MELLITUS, TRANSIENT ISCHAEMIC ATTACK. Managed conservatively. General Physician Consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. TONACT-ASP 150 MG ONCE DAILY AT 8PM FOR 7 DAYS

2) TAB. TRYCIT PLUS ONCE DAILY AT 8AM FOR 7 DAYS

3) TAB. MAXGALIN 75 MG ONCE DAILY AT 8PM FOR 7 DAYS

4) TAB. ZORYL MV2 TWICE DAILY AT 8AM AND 8PM TO CONTINUE

REVIEW AFTER 7 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001231687		**Name**	Mr. RAJU K		
	Patient Identifier	ARHIP55999		**Age**	56Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	04-Jun-2022
	Date of Discharge				
	MLC No				
	Address	centenary colony,peddapalli,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

CORONARY ANGIOGRAM (07/06/2022) -CAD-SVD [LAD proximal moderate stenosis]

PLAN MEDICAL MANAGEMENT

R/F : HTN, T2DM

C/o chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 56 years old male patient K. RAJU came with c/o chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], CORONARY ANGIOGRAM (07/06/2022) -CAD-SVD [LAD proximal moderate stenosis], PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. DAPAGLYN M 500 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. COVERSYL 2 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

.0001227014		**Name**	Mrs. KOTA ELLAVVA		
	Patient Identifier	ARHIP55972		**Age**	60Yr 4Mth 10Days
	Sex	Female		**Date of Admission**	02-Jun-2022
	Expired Date	03-Jun-2022			
	MLC No				
	Address	JANNARAM, MANCHERIAL,Mancherial,Telangana		**Ward/Bed No**	First Floor,

MICU, Bed no:MICU 1

Primary Consultant Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE

Consultants

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
UREMIC ENCEPHALOPATHY.	Pd

C/o altered sensorium

K/c/o peripheral arterial disease

AT ADMISSION:

PR: 108/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94%

P/A: Soft

A 60 years old female patient Mrs. KOTA ELLAVVA came with c/o altered sensorium, K/c/o peripheral arterial disease . All necessary investigations were done and diagnosed as UREMIC ENCEPHALOPATHY. Poor prognosis explained to the patient attendants, suddenly patient unresponsive. CPR started immediately,INJ. Atropine and INJ. ADRENALINE given emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given, CPR continued for 40 minutes, according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.31 PM on 02/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO UREMIC ENCEPHALOPATHY

ARH1.0001231666	**Name**	Mr. NASAR .			
	Patient Identifier	ARHIP55988	**Age**	62Yr 0Mth 4Days	
	Sex	Male	**Date of Admission**	03-Jun-2022	
	Expired Date	07-Jun-2022			
	MLC No				
	Address	peddampeta,kamanpur,peddapally,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 12	
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY	**Consultants**		
	Surgeons		**Anesthesiologists**		

Cause of Death

Cause of Death

Diagnosis

Diagnosis

Disease	Disease Type
CVA WITH POSTRIOR CIRCULATORY STROKE.	

C/o Vomitings, loss of speech

AT ADMISSION:

Patient drowsy

PR: 102/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

GCS-E4V2M1

A 62 years old male patient NASAR came with c/o vomitings, loss of speech. All necessary investigations were done and diagnosed as CVA WITH POSTRIOR CIRCULATORY STROKE. Poor prognosis explained to the patient attendants, patient need to intubate but patient attendants not willing for intubate & ventilator support. On 07/06/2022 at 9.30 AM patient gasping stage, decreased SPO2, brady cardia. CPR started immediately, INJ. Atropine and INJ. ADRENALINE given according to ACLs guidelines. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.16 AM on 07/06/2022.

CAUSE OF DEATH

ASPIRATION PNEUMONIA WITH CVA, POSTERIOR CIRCULATORY STROKE.

ARH1.0001231978			**Name**	Mrs. SAROJA T	
Patient Identifier	ARHIP56102			**Age**	50Yr 0Mth 3Days
Sex	Female			**Date of Admission**	10-Jun-2022
Date of Discharge	12-Jun-2022				
MLC No					
Address	RKP,Karimnagar,Telangana			**Ward/Bed No**	First Floor, MICU, Bed no:MICU 1
Primary Consultant	Dr. KRISHNA CHAITANYA M --			**Consultants**	

Surgeons	CARDIOLOGY Dr. KRISHNA CHAITANYA M -- CARDIOLOGY	**Anesthesiologists**

Diagnosis

Diagnosis

Disease	Disease Type

CORONARY ARTERY DISEASE-NSTEMI(TROP-I POSITIVE)
NORMAL LV FUNCTION
CAG DONE ON 11/06/2022(MINOR CAD)
PLAN-MEDICAL MANAGEMENT

C/o chest pain and giddiness a/w sweating since 1 day

K/c/o T2DM

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 118/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 50 years old female patient SAROJA came with c/o chest pain and giddiness a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-NSTEMI(TROP-I POSITIVE), NORMAL LV FUNCTION, CAG DONE ON 11/06/2022(MINOR CAD), PLAN-MEDICAL MANAGEMENT. Patient was treated with antiplatelets, anticoagulation, antacids and other supportive measures. Patient is being

discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN-AV 75/10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. MET-XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. TELMA-AM 40/5 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. DAPAGY 10MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001010608		**Name**	Mr. J RAGHUPATHI		
	Patient Identifier	ARHIP55993		**Age**	64Yr 10Mth 9Days
	Sex	Male		**Date of Admission**	04-Jun-2022
	Date of Discharge				
	MLC No				
	Address	4-73/8 SARASWATHI NGAR THEEGALAGUTTAPALLI,Karimnagar,Andhra Pradesh		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 5
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH			

CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE+DM+HTN+ S/P LUMBAR LAMINECTOMY, +S/P LEFT VARICOSE VEIN SURGERY+THROMBOCYTOPENIA, HYPOTHYROIDISM

SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO RI, D1] DONE ON 07/06/2022.

C/o retrosternal chest pain a/w sweating since 1 day

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 64 years old male patient Mr. RAGHUPATHI presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE+DM+HTN+ S/P LUMBAR LAMINECTOMY+S/P LEFT VARICOSE VEIN SURGERY+THROMBOCYTOPENIA, HYPOTHYROIDISM, SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO RI, D1] DONE ON 07/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, CONCENTRIC LVH, NORMAL LV SYSTOLIC FUNCTION, GRADE-I DIASTOLIC DYSFUNCTION, NO PE/CLOT/VEG

BMI is 24.8 kg/m2.

Sr. Creatinine report on 07.06.2022 1.2 mg/dl.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH TSH REPORT

ARH1.0001225175		**Name**	Mr. M SANJEEV
Patient Identifier	ARHIP56077	**Age**	29Yr 8Mth 4Days
Sex	Male	**Date of Admission**	09-Jun-2022
Date of Discharge			
MLC No			
Address	3-94 KAMMARI WADA RUDRAVARAM VEMULAWADA ,Sircilla,Telangana		

ACUTE GASTROENTERITIS
HYPOTENSION
RHABDOMYOLYSIS

C/o fever, loose motion, vomiting since 1 day multiple episodes

History of CKD on MHD last on 07/06/2022

AT ADMISSION:

Afebrile

PR: 80/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

A 29 years old male patient Mr. M SANJEEV came with c/o fever, loose motion, vomiting since 1 day multiple episodes. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, HYPOTENSION,
RHABDOMYOLYSIS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.
DISCHARGE MEDICATION:

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1. TAB. FEBUGET 40 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM FOR 7 DAYS.
3. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. NICARDIA RETARD 20 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
6. TAB. PRAXORIL 5 MG TWICE DAILY AT 9AM 9PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD

ARH1.0001226340		**Name**	Mr. AKKALA THIRUPATHI
Patient Identifier	ARHIP56101	**Age**	41Yr 5Mth 6Days
Sex	Male	**Date of Admission**	10-Jun-2022
Date of Discharge			
MLC No			
Address	CHINTAPALLE ADILABAD ,Nirmal,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:108 B
Primary Consultant	Dr. SURESH GOUD S(		

RIGHT URETERIC CALCULUS

SURGERY: RIGHT URSL + DJ STENTING ON 11/06/2022

C/o abdominal pain since 1 day.

ON ADMISSION

Patient c/c

Afebrile

PR-90/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-98%

A 41 years old male patient Mr. AKKALA THIRUPATHI presented to hospital with c/o abdominal pain since 1 day. All necessary investigations were done and diagnosed as RIGHT URETERIC CALCULUS, SURGERY: RIGHT URSL + DJ STENTING ON 11/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 11 DAYS
5. TAB: URIMAX 0.4 MG ONCE DAILY AT 8PM FOR 7 DAYS
6. SYP. K-CIT 10 ML THRICE DAILY AT 8AM 2PM & 8 P.M.

REVIEW AFTER 7 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001159170	**Name**	Mr. SHAIK KAREEMUDDIN			
	Patient Identifier	ARHIP55961		**Age**	43Yr 1Mth 25Days
	Sex	Male		**Date of Admission**	01-Jun-2022
	Date of Discharge				
	MLC No				
	Address	6-3-125,NEAR MASJIDKHANPURA,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 6
	Primary Consultant	Dr SOMASHEKAR K(MS,			

SEVERE CALCIFIC AORTIC STENOSIS WITH SEVERE LV DYSFUNCTION [EF-30%] WITH PSYCHIATRIC ILLNESS- BIPOLAR DISORDER, CERVICAL SPONDYLOSIS

Surgery: AORTIC VALVE REPLACEMENT WITH TTKC NO 21 MM MECHANICAL VALVE DONE ON 08/06/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 43 years old male patient Mr. SHAIK KAREEMUDDIN came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as SEVERE CALCIFIC AORTIC STENOSIS WITH SEVERE LV DYSFUNCTION [EF-30%] WITH PSYCHIATRIC ILLNESS- BIPOLAR DISORDER, CERVICAL SPONDYLOSIS, **Surgery:** AORTIC VALVE REPLACEMENT WITH TTKC NO 21 MM MECHANICAL VALVE DONE ON 08/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST AVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, CONCENTRIC LVH, MODERATE LV DYSFUNCTION. NO CLOT/PE/VEG

BMI is 22 kg/m2.

Sr. Creatinine report done on 09.06.2022 1.3 mg/dl

DISCHARGE MEDICATION:

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1) TAB. ACITROM 1 MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE FOR LIFE LONG.

2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE

4) TAB. PROLOMET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. ARIPIRAZOLE 5 MG ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. DRAZEP 2TAB ONCE DAILY AT 8PM TO CONTINUE.

7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

9) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001231852		**Name**	Mr. PRAVEENKUMAR GANKIDI
Patient Identifier	ARHIP56070	**Age**	34Yr 0Mth 5Days
Sex	Male	**Date of Admission**	08-Jun-2022
Date of Discharge			
MLC No			
Address	NARSAPUR,Nirmal,Telangana	**Ward/Bed No**	Second Floor, Male General Ward, Bed no:GW 21
Primary Consultant	Dr. SURESH GOUD S		

RIGHT PROXIMAL URETERIC CALCULUS
RIGHT PUSH BACK PCNL + DJ STENTING DONE ON 09.06.2022

C/o Right loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 34 yrs old male patient Mr. PRAVEENKUMAR GANKIDI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT PROXIMAL URETERIC CALCULUS, RIGHT PUSH BACK PCNL + DJ STENTING DONE ON 09.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001231803		**Name**	Ms. SHOBHA RANI K	
Patient Identifier	ARHIP56035		**Age**	56Yr 0Mth 6Days
Sex	Female		**Date of Admission**	07-Jun-2022
Date of Discharge				
MLC No				
Address	FLAT NO:308, KAILASA RESIDENCY, OPP APOLLO REACH HOSPITAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION

MILD LV SYSTOLIC DYSFUNCTION, EF-44%

CORONARY ANGIOGRAM DONE ON 07/06/2022 – CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 13 MM PRONOVA DONE ON 07/06/2022
ESBL, E,COLI, URINARY TRACT INFECTION

C/o chest pain, fever, burning micturition since 2 days

AT ADMISSION:

PR: 109/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96% on room air

P/A: Soft

A 56 years old female patient Ms. SHOBHA RANI K came with c/o chest pain, fever, burning micturition since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION, MILD LV SYSTOLIC DYSFUNCTION, EF-44%, CORONARY ANGIOGRAM DONE ON 07/06/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 13 MM PRONOVA [LOT NO: 5211889, S/N :05060127249091] DONE ON 07/06/2022, ESBL, E,COLI, URINARY TRACT INFECTION. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. NOVASTAT 40MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

6) TAB. FAROPENUM 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231985		**Name**	Mr. BHOOMAIAH THADAKAPALLY		
	Patient Identifier	ARHIP56114		**Age**	53Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	10-Jun-2022
	Date of Discharge				
	MLC No				
	Address	somarampet,rajanna sircilla,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 5
	Primary Consultant	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY			

S

CORONARY ARTERY DISEASE, AWSTEMI

SEVERE LV DYSFUNCTION, EF-40%

R/F: CHRONIC SMOKER

CORONARY ANGIOGRAM DONE ON 10/06/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 19 MM METAFOR DONE ON 10/06/2022

C/o Retrosternal chest pain, sweating since 2 days

AT ADMISSION:

Afebrile

PR: 97/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95% on room air

P/A: Soft

A 53years old male patient Mr. BHOOMAIAH THADAKAPALLY came with c/o retrosternal chest pain, sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWSTEMI, SEVERE LV DYSFUNCTION, EF-40%, R/F: CHRONIC SMOKER, CORONARY ANGIOGRAM DONE ON 10/06/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 19 MM METAFOR [LOT NO: MH23, S/N CM19MH23041]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPIDOGREL 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8AM TO CONTINUE.

4) TAB. FRUSELAC DS 40/25 ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP-II REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001218781		**Name**	Mrs. CHANDRAMMA J
Patient Identifier	ARHIP55943	**Age**	60Yr 10Mth 9Days
Sex	Female	**Date of Admission**	31-May-2022
Date of Discharge			
MLC No			
Address	GATTUDUDDENAPALLY,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:103 A
Primary Consultant	Dr. RAMCHANDER TORRE		

ACUTE ON CHRONIC KIDNEY DISEASE

C/o Shortness of breath associated with fever

Known case of CKD, Hypertension & Diabetes mellitus

AT ADMISSION:

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

A 60 years old female patient CHANDRAMMA came with c/o shortness of breath associated with fever. All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE. Managed conservatively. 1 unit RBC transfusion given. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. FAROALFA 200 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. CILACAR M 10/50 **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
3. TAB. SOBINIX DS ONCE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. ESOCLOCK DSR 40 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
6. TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. CUDCE FORT THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
8. SYP. GRYLLINCTUS 1 tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
9. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
10. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001206329		**Name**	Mr. POREDDY MALLA REDDY		
	Patient Identifier	ARHIP56110		**Age**	65Yr 3Mth 0Days
	Sex	Male		**Date of Admission**	10-Jun-2022
	Date of Discharge				
	MLC No				
	Address	10-4-291/1/D, VAVILALAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:122 A
	Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY			

CHRONIC CALCULUS CHOLECYSTITIS
SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022

C/o pain abdomen on and off since few days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 65 yr old male patient Mr. POREDDY MALLA REDDY came with c/o pain abdomen on and off since few days. All necessary investigations done and diagnosed as CHRONIC CALCULUS CHOLECYSTITIS, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 06.05.2022. Findings: Few omental adhesions with thickened gallbladder wall and inflammatory changes, short cystic duct. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVAULT –V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001231817		**Name**	Mr. EDLA BANAIAH
Patient Identifier	ARHIP56044	**Age**	66Yr 0Mth 6Days
Sex	Male	**Date of Admission**	07-Jun-2022
Date of Discharge			
MLC No			
Address	CCC,SRIRAMPUR,Mahabubabad,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:120 A
Primary Consultant	Dr. GOUTHAM ROY (MS		

RIGHT INGUINAL INDIRECT COMPLETE HERNIA WITH HYDROCELE

SURGERY : OPEN RIGHT INGUINAL HERNIOTOMY+HYDROCELECTOMY DONE ON 11.06.2022

C/o swelling in right groin region

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 66 yr old male patient EDLA BANAIAH came with c/o swelling in right groin region. All necessary investigations done and diagnosed as RIGHT INGUINAL INDIRECT COMPLETE HERNIA WITH HYDROCELE,

SURGERY : OPEN RIGHT INGUINAL HERNIOTOMY+HYDROCELECTOMY DONE ON 11.06.2022.

Findings: Long studing sac with moderate right hydrocele , indirect defect with bowel loops as its contents. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE-CV TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: ROTAVAULT THRICE IN A DAY AT 8 AM 2 PM & 8 PM FOR 15 DAYS.
5. TAB: ZERODOL SP TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
6. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
7. SCROTAL SUPPORT

Review after 10 days in General Surgery OPD.

ARH1.0001231882		**Name**	Mr. MD ZAHEED		
	Patient Identifier	ARHIP56075		**Age**	62Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:110 A
	Primary Consultant	Dr. RAMCHANDER TORREM			

AKI,
DIABETES MELLITUS
HYPERTENSION

C/o Shortness of breath associated with fever since 1 day

Known case of HTN, T2DM

AT ADMISSION:

PR: 94/min

BP: 160/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

A 62 years old male patient MD ZAHEED came with c/o shortness of breath associated with fever since 1 day . All necessary investigations were done and diagnosed as AKI, DIABETES MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CLOCEF-CV 620 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. CILACAR M 10/50 **ONCE IN A DAY AT 2 PM**TO CONTINUE.
3. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
4. TAB. CUDCE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
5. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
6. TAB. ROZAGOLD ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. VELTAM 0.4 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. DYTOR 10 MG **ONCE IN A DAY AT 2 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD

ARH1.0001231843		**Name**	Mr. M MALLAIAH		
	Patient Identifier	ARHIP56073		**Age**	68Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KELLEDU,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:120 B
	Primary Consultant	Dr. RAMCHANDER TORREM			

ACUTE KIDNEY INJURY

C/o shortness of breath on and off since a few days,
abdominal distension and bloating of stomach since few days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 90/50mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft

A 68 years old male patient MALLAIAH came with c/o shortness of breath on and off since a few days, abdominal distension and bloating of stomach since few days. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CEFURAZ-CV **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
3. TAB. CILACAR M 10 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
4. TAB. VELTAM 0.4 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. ROSAGOLD ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CUDCE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
7. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
8. TAB. MULTI-8 **ONCE IN A DAY AT 2 PM** TO CONTINUE.
9. TAB. UBILIFE **ONCE IN A DAY AT 2 PM** TO CONTINUE.
10. TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD

ARH1.0001231933		**Name**	Mr. M RAJU
Patient Identifier	ARHIP56087	**Age**	50Yr 0Mth 4Days
Sex	Male	**Date of Admission**	09-Jun-2022
Date of Discharge			
MLC No			
Address	1-11,katkoor,siddipet,Siddipet,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:123 B
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ATYPICAL CHEST PAIN, SR

NORMAL LV FUNCTION [EF-65%]

CORONARY ANGIOGRAM (11/06/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient M RAJU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR , NORMAL LV FUNCTION [EF-65%], CORONARY ANGIOGRAM (11/06/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged at request.

DISCHARGE MEDICATION:

---

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 11 DAYS.
4. TAB. ACTON OR TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231822		**Name**	Mr. LACHAIAH SHIVARATHRI
Patient Identifier	ARHIP56049	**Age**	38Yr 0Mth 6Days
Sex	Male	**Date of Admission**	07-Jun-2022
Date of Discharge			
MLC No			
Address	NAMAPALLI, RAJANNA SIRICILLA,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Male General Ward, Bed no:GW 20
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch		

LEFT RENAL CALCULUS
SURGERY : LEFT PCNL + DJ STENTING DONE ON 09.06.2022

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 38 yrs old male patient Mr. LACHAIAH SHIVARATHRI came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT RENAL CALCULUS, SURGERY : LEFT PCNL + DJ STENTING DONE ON 09.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 11DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001231884		**Name**	Mr. RAMULU KAVAMPELLI		
	Patient Identifier	ARHIP56072		**Age**	43Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	2-91 DUNDERPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 10
	Primary Consultant	Dr. Iftekarali (MS (Orthopaedics			

CLOSED COMMINUTED SEGMENTAL FRACTURE SHAFT TIBIA LEFT

SURGERY: LEFT INTERLOCKING TIBIA + FIBULA RUSH NAILING+FASCIOTOMY DONE ON 09/10/2022

Alleged to have sustained injury due to fall from Bullcort while get down himself on 08/06/22 around 8:30 p.m. at work place, sustained injury to left leg

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-84/min
BP-120/80mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-99%

A 43 years old male patient Mr. RAMULU KAVAMPELLI came with alleged to have sustained injury due to fall from Bullcort while get down himself on 08/06/22 around 8:30 p.m. at work place, sustained injury to left leg . All necessary investigations were done and diagnosed as CLOSED COMMINUTED SEGMENTAL FRACTURE SHAFT TIBIA LEFT, SURGERY: LEFT INTERLOCKING TIBIA + FIBULA RUSH NAILING+FASCIOTOMY DONE ON 09/10/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN SR TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. DISENCHER TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
4. TAB. RANTAC 150 MG ONCE DAILY AT 8AM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001230960		**Name**	Mr. VADAKAPURAM DAMODARA CHARY		
	Patient Identifier	ARHIP56067		**Age**	57Yr 0Mth 28Days
	Sex	Male		**Date of Admission**	08-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Alugunur,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW17
	Primary Consultant	Dr. SURESH GOUD			

LEFT URETERIC CALCULUS

SURGERY: LEFT URSL + DJ STENTING DONE ON 09/06/2022

C/o left loin pain, burning micturition since 1 week.

ON ADMISSION

Patient c/c

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 57 years old male patient Mr. VADAKAPURAM DAMODARA CHARY presented to hospital with c/o left loin pain, burning micturition since 1 week. All necessary investigations were done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL + DJ STENTING DONE ON 09/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001231828		**Name**	Mr. BHOOMAIAH CHIKKULA		
	Patient Identifier	ARHIP56052		**Age**	67Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	08-Jun-2022
	Date of Discharge				
	MLC No				
	Address	4-3-82 BEET BAZAR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 11
	Primary Consultant	Dr. RAMCHANDER TORREM			

AKI,
DIABETES MELLITUS
HYPERTENSION

C/o sudden profuse sweating, vertigo, mild SOB since 1 day

Known case of HTN, T2DM,
H/o PTCA 2017

AT ADMISSION:

PR: 84/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

A 67 years old male patient Mr. BHOOMAIAH CHIKKULA came with c/o sudden profuse sweating, vertigo, mild SOB since 1 day . All necessary investigations were done and diagnosed as AKI, DIABETES MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. CLOCEF-CV 620 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
3. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
4. TAB. CUDCE THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
5. TAB. RECLIDE MR ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CARDIVAS 6.25 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
7. TAB. ECOSPRIN 150 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
8. TAB. CLOPILET 75 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
9. TAB. AZTOR 40 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
10. TAB. FEFOQ-8 **ONCE IN A DAY AT 2 PM**TO CONTINUE.
11. TAB. MULTI-8 **ONCE IN A DAY AT 2 PM**TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001231868		**Name**	Mr. AKULA RAMA SWAMI		
	Patient Identifier	ARHIP56064		**Age**	60Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	08-Jun-2022
	Date of Discharge				
	MLC No				
	Address	MANAKONDUR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 22
	Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY			

RTA, TRAUMATIC BRAIN INJURY
ACUTE THIN SDH ON LEFT TEMPORAL REGION
ACUTE HAEMATOMA LEFT TEMPORAL LOBE

Alleged h/o sustained injury due to RTA, slip and fall from 2 wheeler himself history of LOC and vomitings+

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 60 years old male patient Mr. AKULA RAMA SWAMI came with alleged h/o sustained injury due to RTA, slip and fall from 2 wheeler himself, history of LOC and vomitings+. All necessary investigations were done and diagnosed as RTA, TRAUMATIC BRAIN INJURY, ACUTE THIN SDH ON LEFT TEMPORAL REGION , ACUTE HAEMATOMA LEFT TEMPORAL LOBE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

2) TAB. LIBRIUM 20 MG ONCE DAILY AT 8PM FOR 10 DAYS

3) TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) TAB. THIAMINE 100 MG ONCE DAILY AT 2PM FOR 10 DAYS

5) TAB. ND Q10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001231790		**Name**	Mrs. KANAKAM VENKATAMMA		
	Patient Identifier	ARHIP56032		**Age**	65Yr 0Mth 7Days
	Sex	Female		**Date of Admission**	07-Jun-2022
	Date of Discharge				
	MLC No				
	Address	H.NO:70,MUTHARAM,KARIMNAGAR,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI

MILD LV DYSFUNCTION, EF-45%

R/F: ALCOHOLIC

CORONARY ANGIOGRAM DONE ON 09/06/2022 – CAD-DVD (LAD, LCX)

PTCA+DES TO LAD WITH 2.5 X 37 MM METAFOR DONE ON 09/06/2022
PLAN MEDICAL MANAGEMENT FOR LCX [CTO]

C/o sudden onset of chest pain 1 day

AT ADMISSION:

Afebrile

PR: 84/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65years old male patient Mrs. KANAKAM VENKATAMMA came with c/o sudden onset of chest pain 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV DYSFUNCTION, EF-45%, R/F: ALCOHOLIC, CORONARY ANGIOGRAM DONE ON 09/06/2022 – CAD-DVD (LAD, LCX), PTCA+DES TO LAD WITH 2.5 X 37 MM METAFOR DONE ON 09/06/2022, PLAN MEDICAL MANAGEMENT FOR LCX [CTO]. Neurophsyician consultation taken and advice followed. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. PROLOMET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

8) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001185936		**Name**	Mrs. ANKAM SAROJANA
Patient Identifier	ARHIP55991	**Age**	48Yr 10Mth 24Days
Sex	Female	**Date of Admission**	04-Jun-2022
Date of Discharge			
MLC No			
Address	17-23/ A,MANTHANI,PEDDAPALLI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 2
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS		

CRHD WITH SEVERE MS WITH PAH, HYPOTHYROIDISM

Surgery: MITRAL VALVE REPLACEMENT WITH TTKC NO. 29 mm, MECHANICAL VALVE DONE ON 09/06/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 48 years old female patient Mrs. ANKAM SAROJANA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CRHD WITH SEVERE MS WITH PAH, HYPOTHYROIDISM, Surgery: MITRAL VALVE REPLACEMENT WITH TTKC NO. 29 mm, MECHANICAL VALVE DONE ON 09/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED POST MVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL LV FUNCTION. NO CLOT/PE/VEG, [EF-60%]

BMI is 12.7 kg/m2.

Sr. Creatinine report done on 10.06.2022 0.8 mg/dl

DISCHARGE MEDICATION:

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1) TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE FOR LIFE LONG.

2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ELTROXIN 50 MCG ONCE DAILY AT 8AM TO CONTINUE.

4) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE

5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

6) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT-INR REPORTS

ARH1.0001231874		**Name**	Mrs. J SUSHEELA
Patient Identifier	ARHIP56065	**Age**	68Yr 0Mth 6Days
Sex	Female	**Date of Admission**	08-Jun-2022
Date of Discharge			
MLC No			
Address	JAGITYAL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU1 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

MODERATE LV DYSFUNCTION, EF-35%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 11/06/2022 – CAD-DVD (LAD, RCA)

PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA DONE ON 11/06/2022
MEDICAL MANAGEMENT FOR RCA [CTO]

C/o chest pain a/w SOB since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 68years old female patient Mrs. J SUSHEELA came with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV DYSFUNCTION, EF-35%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 11/06/2022 – CAD-DVD (LAD, RCA), PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA [LOT NO: CC200530018038, S/N :9990] DONE ON 11/06/2022. MEDICAL MANAGEMENT FOR RCA [CTO]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. BETALOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231974		**Name**	Mr. GANGADHAR BUDDARAPU
Patient Identifier	ARHIP56104	**Age**	52Yr 0Mth 4Days
Sex	Male	**Date of Admission**	10-Jun-2022
Date of Discharge			
MLC No			
Address	ANGADI BAZAR,JAGTIAL,Other,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. KRISHNA CHAITANYA M		

CORONARY ARTERY DISEASE, AWSTEMI

MODERATE LV DYSFUNCTION, EF-35%

R/F: T2DM

S/P CORONARY ANGIOGRAM DONE ON 13/06/2022 – CAD-TVD

PLAN CABG.

C/o sudden onset chest pain followed by profuse sweating

No history of syncope, pedal oedema, breathing difficulty

At Admission

Afebrile

PR: 93/min

BP: 130/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 52 years old male patient Mr. GANGADHAR BUDDARAPU had history of chest discomfort and profuse sweating was assessed at local hospital where he was managed as STEMI - Anterior wall and thrombolised with Tenecteplase 35 mg. He was referred to us for further management, on evaluation, he was asymptomatic, haemodynamically stable. ECG showed significant ST resolution. On Coronary Angiogram showed Triple Vessel Disease with a calcific thrombotic LAD, significant (> 70%) lesion in RCA and LCX. We advised myocardial viability testing (cardiac MRI, Tralium) for LAD territory. If LAD territory is viable, explained that CABG is the first option, in case LAD territory is non-viable, advised re-vascularization of RCA and LCX. Patient family wanted to taken him for Higher Centre for CABG. Hence being discharged for further management, he was asymptomatic at rest and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM FOR 11 DAYS
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001232104		**Name**	Mr. G LOKESH
Patient Identifier	ARHIP56173	**Age**	36Yr 0Mth 0Days
Sex	Male	**Date of Admission**	14-Jun-2022
Date of Discharge			
MLC No			
Address	jagityal,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 9
Primary Consultant	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY		

MINOR CORONARY ARTERY DISEASE

CORONARY ANGIOGRAM (14/06/2022) -LAD SLOW FLOW

C/o palpitations, left sided chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 36 years old male patient LOKESH came with c/o palpitations, left sided chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as MINOR CORONARY ARTERY DISEASE, LAD SLOW FLOW, CORONARY ANGIOGRAM (14/06/2022) -LAD slow flow, PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 3 MONTHS / SOS

ARH1.0001232117		**Name**	Mr. BHOOMAIAH G
Patient Identifier	ARHIP56171	**Age**	62Yr 0Mth 1Days
Sex	Male	**Date of Admission**	14-Jun-2022
Date of Discharge			
MLC No			
Address	THEEGALAGUTTAPALLI,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 8
Primary Consultant	Dr. KRISHNA CHAITANYA		

CORONARY ARTERY DISEASE, AWMI

FAIR LV FUNCTION

CORONARY ANGIOGRAM DONE ON 14/06/2022 -CAD-SVD (LAD)

PLAN : PTCA+DES TO LAD [EARLY]

C/o chest discomfort, generalized bodyache

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 87/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 62 years old male patient BHOOMAIAH came with c/o chest discomfort, generalized bodyache. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, FAIR LV FUNCTION , CORONARY ANGIOGRAM (14/06/2022) -CAD-SVD (LAD), In view of critical mid LAD 99% stenosis, he was advised to early angioplasty. Risk of total occlusion followed by sudden cardiac arrest explained due to relative.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. AMLODAC 5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232060		**Name**	Mrs. DUDAM SATHTHAVVA
Patient Identifier	ARHIP56152	**Age**	54Yr 5Mth 2Days
Sex	Female	**Date of Admission**	13-Jun-2022
Date of Discharge			
MLC No			
Address	3-6-135, SHANTHI NAGAR,Sircilla,Telangana	**Ward/Bed No**	First Floor, HDU, Bed no:HDU 2
Primary Consultant	Dr. KRISHNA CHAITANYA M		

CORONARY ARTERY DISEASE

CORONARY ANGIOGRAM (14/06/2022) -LAD –ECTATIC CORONARIES -SLOW FLOW

C/o chest pain since 5 days associated with sweatings

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94%

P/A: Soft

A 54 years old female patient Mrs. DUDAM SATHAVVA came with c/o chest pain since 5 days associated with sweatings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, CORONARY ANGIOGRAM (14/06/2022) -LAD – ECTATIC CORONARIES -SLOW FLOW. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. FLAVEDON MR AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH TSH, FLP, FBS, CBC, RP2

ARH1.0001231972		**Name**	Mrs. MANCHIKATLA VIJAYA		
	Patient Identifier	ARHIP56098		**Age**	54Yr 0Mth 5Days
	Sex	Female		**Date of Admission**	10-Jun-2022
	Date of Discharge				
	MLC No				
	Address	gandhi road, jagityal,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. KRISHNA CHAITANYA M			

ACS -AWSTEMI
SEVERE LV DYSFUNCTION
PULMONARY OEDEMA
MILD MR
HF
CARDIOGENIC SHOCK
KILLIP CLASS -III
NOW S/P PRIMARY PTCA TO LAD TOTAL OCCLUSION WITH A 2.75 X 32 MM METAFOR STENT GOOD RESULT
UNCONTROLLED DIABETES

C/o chest pain sudden onset, followed by profuse sweating
History of cough+

Known case of hypertension, diabetes mellitus on regular treatment

AT ADMISSION:

Afebrile

PR: 104/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old female patient Mrs. MANCHIKATLA VIJAYA came with c/o chest pain sudden onset, followed by profuse sweating, history of cough+. All necessary investigations

were done and diagnosed as ACS –AWSTEMI, SEVERE LV DYSFUNCTION, PULMONARY OEDEMA , MILD MR , HF , CARDIOGENIC SHOCK , KILLIP CLASS -III , NOW S/P PRIMARY PTCA TO LAD TOTAL OCCLUSION WITH A 2.75 X 32 MM METAFOR STENT , GOOD RESULT , UNCONTROLLED DIABETES. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPIDOGREL 70MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

5) TAB. ALDACTONE 25 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. IVABID 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

8) TAB. LASIX 40MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

9) TAB. ZORYL M2 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

10) TAB. CARVEDILOL 6.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS [22/06/2022] TO CARDIAC OPD WITH CBC, EFT/SE, ECG, FBS, FLP REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001226434		**Name**	Mrs. AKKALA SATTAVVA		
	Patient Identifier	ARHIP56162		**Age**	40Yr 5Mth 14Days
	Sex	Female		**Date of Admission**	13-Jun-2022
	Date of Discharge				
	MLC No				
	Address	LAXETTIPET,MANCHERIAL,Tandur,Telangana		**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 6
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL			

PARTIAL HANGING

Alleged history of hanging at 2.10 p.m. on 13/06/2022
Initially treated at outside hospital in unresponsive state along with seizures, came here for further management

Known case of psychiatric illness not on regular medication

AT ADMISSION:

Patient was on mechanical ventilator

GCS-2T/15

PR: 80/min

BP: 130/70 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old female patient Mrs. AKKALA SATTAVVA patient presented with the above-mentioned complaints, patient was brought in an intubated state MRI brain and MRI cervical spine was done which revealed no significant abnormality. On the second day of hospitalisation patient

was weaned off ventilation and Psychiatric consultation was taken. Patient condition improved. Patient is being discharged in hemodynamically stable condition.

DISCHARGE MEDICATION:

---

1) TAB. SIZODON 1 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. PACITANE 2 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 7 DAYS

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD

ARH1.0001231889		**Name**	Mrs. SHOBA VELMALA		
	Patient Identifier	ARHIP56076		**Age**	38Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	NIRAMAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

COMPLETE HEART BLOCK
NORMAL LV SYSTOLIC FUNCTION, EF 56%
TPI DONE ON 12/06/2022
PPI DONE ON 12/06/2022 WITH MEDTRONIC [VVIR] DONE ON 12/06/2022

C/o chest pain radiating to back a/w SOB since 1 day

AT ADMISSION:

Afebrile

PR: 39/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 38years old female patient Mrs. SHOBA VELMALA came with c/o chest pain radiating to back a/w SOB since 1 day. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK, NORMAL LV SYSTOLIC FUNCTION, EF 56%, TPI

DONE ON 12/06/2022, PPI DONE ON 12/06/2022 WITH MEDTRONIC [VVIR] DONE ON 12/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. AUGMENTIN DUO 625MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

2) TAB. BEPLEX FORTE ONCE DAILY AT 2PM FOR 10 DAYS

3) T-BACT OINTMENT FOR L/A

4) TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231918		**Name**	Mrs. SHANTHA ERLA	EDIT	
	Patient Identifier	ARHIP56085		**Age**	56Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KAGAZNAGAR,Tandur,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI

MILD MR, SR

MILD LV DYSFUNCTION, EF-50%

R/F: ALCOHOLIC

CORONARY ANGIOGRAM DONE ON 16/10/2021 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52years old male patient Mr. GANDLA SHANKARAIAH came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MILD MR, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 16/10/2021 – CAD-SVD (LAD), Type-III vessel, proximal LAD significant stenisis. PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232075		**Name**	Mrs. BAILU RAJAMMA		
	Patient Identifier	ARHIP56146		**Age**	60Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	13-Jun-2022
	Date of Discharge				
	MLC No				
	Address	8-129, UPPARAPALLI, ODELA, PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME2
	Primary Consultant	DR. SRI KARAN UDDESH --			

COMPLICATED UTI,
RENAL CALCULI

C/o fever associated with pain abdomen, burning micturition
Known case of type II diabetes mellitus, hypertension on regular medication

AT ADMISSION:

Afebrile

PR: 65/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. BAILU RAJAMMA came with above mentioned complaints. Patient diagnosed as COMPLICATED UTI, RENAL CALCULI. Patient was treated with antibiotics. Patient's condition improved since admission. CT-KUB done and Urologist consultation taken and advised surgery for left renal calculi. Now Patient attendants requested for discharge, hence patient is being discharged at request.

DISCHARGE MEDICATION:

---

1) TAB. LEVOFLOX 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. URIMAX 0.4 MG ONCE DAILY AT 2PM FOR 7 DAYS

3) SYP. POTKLAR 15 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 1 DAY

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD

ARH1.0001232095		**Name**	Mrs. KOMALA PANJALA		
	Patient Identifier	ARHIP56161		**Age**	33Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	13-Jun-2022
	Date of Discharge				
	MLC No				
	Address	CENTINARY COLONY,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 5
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATYPICAL CHEST PAIN, SR
NORMAL LV SYSTOLIC FUNCTION
HYPOTHYROIDISM
CORONARY ANGIOGRAM DONE ON 14/06/2022-NORMAL CORONARIES
ADV: MEDICAL MANAGEMENT

C/o left sided chest pain radiating to left arm since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 33 years old female patient Mrs. KOMALA PANJALA came with c/o left sided chest pain radiating to left arm since 10 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION, HYPOTHYROIDISM, CORONARY ANGIOGRAM DONE ON 14/06/2022-NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
4. TAB. THYRONORM 50 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001231918		**Name**	Mrs. SHANTHA ERLA		
	Patient Identifier	ARHIP56085		**Age**	56Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KAGAZNAGAR,Tandur,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION
NORMAL LV SYSTOLIC FUNCTION, EF- 60%
CORONARY ANGIOGRAM DONE ON 11/06/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 23 MM PRONOVA DONE ON 11/06/2022
R/F: HYPERTENSION

C/o SOB on exertion, chest pain, b/l pedal edema since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 56years old female patient Mrs. SHANTHA ERLA came with c/o SOB on exertion, chest pain, b/l pedal edema since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION, NORMAL LV SYSTOLIC FUNCTION, EF- 60%, CORONARY ANGIOGRAM DONE ON 11/06/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 23 MM PRONOVA DONE ON 11/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. TELZY-CT ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. METOLOR-XR 50 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. SPOROLAC DS TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001048529		**Name**	Mr. CHEKKILA RAMULU
Patient Identifier	ARHIP56182	**Age**	52Yr 7Mth 18Days
Sex	Male	**Date of Admission**	14-Jun-2022
Date of Discharge			
MLC No			
Address	2-1-109/2, SRI RAMNAGAR, JAGITIAL,,Karimnagar,Andhra Pradesh	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME4
Primary Consultant	Dr. KRISHNA CHAITANYA		

CORONARY ARTERY DISEASE
S/P PTCA TO LAD
FAIR LV FUNCTION
NOW, CHEST PAIN FOR EVALUATION
LAD STENT PATENT
RCA PROXIMAL 40% STENOSIS
MEDICAL MANAGEMENT

C/o Sudden onset of left sided chest pain associated with shortness of breath

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. CHEKKILA RAMULU came with c/o Sudden onset of left sided chest pain associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, S/P PTCA TO LAD, FAIR LV FUNCTION, NOW, CHEST PAIN FOR EVALUATION, LAD STENT PATENT, RCA PROXIMAL 40% STENOSIS, MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ROSUVAS 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. MET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 3 MONTHS TO CARDIAC OPD WITH APOLLO HEALTHY HEART PACKAGE

ARH1.0001132925		**Name**	Mr. PULLOORI SWAMI
Patient Identifier	ARHIP56096	**Age**	43Yr 0Mth 2Days
Sex	Male	**Date of Admission**	10-Jun-2022
Date of Discharge			
MLC No			
Address	BRAHMANPALLY,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

S/P PTCA STENT TO LAD (2017)

CORONARY ANGIOGRAM DONE ON 13/06/2022 – CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR DONE ON 13/06/2022

C/o chest pain a/w mild sweating since 1 day

AT ADMISSION:

Afebrile

PR: 87/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 43 years old male patient Mr. PULLOORI SWAMI came with c/o chest pain a/w mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, S/P PTCA STENT TO LAD (2017), CORONARY ANGIOGRAM DONE ON 13/06/2022 – CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR [LOT NO: MH22, S/N :CM37MH22002] DONE ON 13/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001231920		**Name**	Mr. PARSHARAM KAVVAMPALLY		
	Patient Identifier	ARHIP56084		**Age**	52Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	09-Jun-2022
	Date of Discharge				
	MLC No				
	Address	GANNERVARAM,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 13/06/2022 – CAD-DVD (LAD, RCA)

PTCA+DES TO RCA & LAD (TWO STENTS) LAD WITH 3.0 X 24 MM METAFOR, RCA WITH 3.0 X 44 MM METAFOR
DONE ON 13/06/2022

C/o chest pain since 2 days a/w sweating, giddiness

AT ADMISSION:

Afebrile

PR: 78/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. PARSHARAM KAVVAMPALLY came with c/o chest pain since 2 days a/w sweating, giddiness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 13/06/2022 – CAD-DVD (LAD, RCA), PTCA+DES TO RCA & LAD (TWO STENTS) LAD WITH 3.0 X 24 MM METAFOR, RCA WITH 3.0 X 44 MM METAFOR [LOT NO: MH42, S/N :CM24MH42083] [LOT NO: MG92, S/N :CM44MG92015] DONE ON 13/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

4) TAB. ATORVA 80MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232008		**Name**	Mrs. LOKURTHI ANJALI		
	Patient Identifier	ARHIP56126		**Age**	47Yr 5Mth 4Days
	Sex	Female		**Date of Admission**	11-Jun-2022
	Date of Discharge				
	MLC No				
	Address	2-28/1, KORUTLAPETA,RAJANNA,Sircilla,Telangana		**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 7
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATYPICAL CHEST PAIN WITH ECG CHANGES, SR

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

R/F: HTN

CORONARY ANGIOGRAM (14/06/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o chest pain on and off, SOB on exertion since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 47 years old female patient Mrs. LOKURTHI ANJALI came with c/o chest pain on and off, SOB on exertion since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], R/F: HTN, CORONARY ANGIOGRAM (14/06/2022) -NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. PROLOMET-R 25/2.5 ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232062		**Name**	Mrs. B VENKATA NARSAMMA
Patient Identifier	ARHIP56145	**Age**	57Yr 5Mth 14Days
Sex	Female	**Date of Admission**	13-Jun-2022
Date of Discharge			
MLC No			
Address	RAMADUGU,,Karimnagar,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME5
Primary Consultant	DR. SRI KARAN UDDESH		

COMPLICATED UTI,
RENAL CALCULI

C/o fever associated with pain abdomen, burning micturition since 3-4 days

Known case of hypertension on regular medication

AT ADMISSION:

Afebrile

PR: 88/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% on room air

P/A: Soft

A 57 years old female patient Mrs. B VENKATA NARSAMMA came with above mentioned complaints. Patient diagnosed as COMPLICATED UTI, RENAL CALCULI. Patient was treated with antibiotics. Patient's condition improved since admission. CT-KUB done and Urologist consultation taken and advised surgery Right DJ stent, for right PUJ calculus. Now Patient attendants requested for discharge, hence patient is being discharged at request.

DISCHARGE MEDICATION:

---

1) TAB. LEVOFLOX 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. URIMAX 0.4 MG ONCE DAILY AT 2PM FOR 7 DAYS

3) SYP. POTKLAR 15 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 1 DAY

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD

ARH1.0001231981		**Name**	Mr. RAJAIAH S		
	Patient Identifier	ARHIP56115		**Age**	69Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	10-Jun-2022
	Date of Discharge				
	MLC No				
	Address	BHAGATH NAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 8
	Primary Consultant	Dr. KRISHNA CHAITANYA M --			

CORONARY ARTERY DISEASE, IWSTEMI [THROMBOLISED BY TENECTEPLASE (OUTSIDE)]
FAIR LV FUNCTION, LVEF-50%

S/P PTCA TO RCA (2 STENTS) WITH METAFOR [2.75 X 40 mm], METAFOR [2.5 X 16 mm] done on 13.06.2022

NO HF

FC I AT REST

LMCA+LAD MILD DISEASE FOR MEDICAL MANAGEMENT NOW

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 69 years old male patient RAJAIAH came with history of chest pain was diagnosed as IWSTEMI and thrombolised with TENECTEPLASE at a local hospital and referred to us for further management. On evaluation patient was taken up for CAG which showed two RCA lesions. RCA was revascularized with 2 stents. He also has mild LMCA and osteoproximal LAD disease which were planned for medical management with high intensity statin therapy. He improved symptomatically and became better. He was haemodynamically stable and hence, being discharged with the following advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW ON 22/06/22 TO CARDIAC OPD WITH CBC, RP-2 REPORTS

ARH1.0001162967		**Name**	Mr. LACHI REDDY GAGIREDDY		
	Patient Identifier	ARHIP56155		**Age**	58Yr 9Mth 1Days
	Sex	Male		**Date of Admission**	13-Jun-2022
	Date of Discharge				
	MLC No				
	Address	kachapur,peddapalli,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI

MILD LV DYSFUNCTION, EF-45%

S/P CORONARY ANGIOGRAM DONE ON 13/04/2022 – CAD-TVD (LAD, LCX, RCA)

CABG WITH GRAFT TO LAD, RAMUS, RCA

R/F: HTN

C/o Retrosternal chest pain since 1 day

At Admission

Afebrile

PR: 78/min

BP: 120/80 mmHg

RR-18/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 58 years old male patient Mr. LACHI REDDY GAGIREDDY came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MILD LV DYSFUNCTION, EF-45%, S/P CORONARY ANGIOGRAM DONE ON 13/04/2022 – CAD-TVD (LAD, LCX, RCA), Patient is planned for CABG WITH GRAFT TO LAD, RAMUS, RCA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. SYP. POTKLOR 15 ML THRICE DAILY AT 8AM, 2PM, 8PM

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001232043		**Name**	Mrs. PREAMALATHA G
Patient Identifier	ARHIP56141	**Age**	69Yr 0Mth 3Days
Sex	Female	**Date of Admission**	13-Jun-2022
Date of Discharge			
MLC No			
Address	11-2-303 INDIRA NAGAR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE , ACUTE LVF

SEVERE LV DYSFUNCTION, EF-30%

S/P CORONARY ANGIOGRAM DONE ON 15/06/2022 – CAD-TVD

ADV: CABG.

R/F HTN,

C/o chest pain a/w SOB, mild sweating since 1 day

At Admission

Afebrile

PR: 86/min

BP: 140/90 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 69 years old female patient Mrs. PREAMALATHA G came with c/o chest pain a/w SOB, mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE LVF, SEVERE LV DYSFUNCTION, EF-30% , S/P CORONARY ANGIOGRAM DONE ON 15/06/2022 – CAD-TVD, ADV: CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPIDOGREL 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. CAP. ANGISPAN TR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

ARH1.0001232096		**Name**	Mr. G CHANDRAIAH	
Patient Identifier	ARHIP56164		**Age**	62Yr 0Mth 3Days
Sex	Male		**Date of Admission**	13-Jun-2022
Date of Discharge				
MLC No				
Address	POLAMPALLI THIMMAPUR KARIMNAGAR,Karimnagar,Telangana		**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 3
Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY			

RTA POLYTRAUMA
SEVERE TRAUMATIC BRAIN INJURY
MULTIPLE HAEMORRHAGIC CONTUSIONS BILATERAL BASIFRONTAL, BASITEMPORAL
BILATERAL THIN ACUTE SDH
FRACTURE GREATER WING OF SPHENOID, TEMPORAL BONE, MASTOID RIGHT SIDE
DIFFUSE CEREBRAL EDEMA
BRUST LEFT TEMPORAL LOBE WITH MASS EFFECT
SAH
COMMINUTED FRACTURE HUMERUS LEFT
FRACTURE LEFT 4TH METATARSAL LEFT
FRACTURE LATERAL MALLEOLUS LEFT
SURGERY: LEFT SIDE FTP DECOMPRESSIVE CRANIECTOMY DONE ON 14/06/2022

Alleged history of RTA 2 wheeler Vs Tractor at 5 p.m. on 13/60/2022 followed by sustained polytrauma injury

History of LOC, Vomitings, ENT bleeding present

PHYSICAL EXAMINATION:

ON ADMISSION

Patient is unconscious

PR-96/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-99% with O2 support

GCS E1, V1, M3

A 62 yrs old male patient Mr. CHANDRAIAH came with alleged history of RTA 2 wheeler Vs Tractor at 5 p.m. on 13/60/2022 followed by sustained polytrauma injury , history of LOC, Vomitings, ENT bleeding present. Patient was intubated in view of threatened airway and aspirations. All necessary investigations done and diagnosed as RTA POLYTRAUMA, SEVERE TRAUMATIC BRAIN INJURY, MULTIPLE HAEMORRHAGIC CONTUSIONS BILATERAL BASIFRONTAL, BASITEMPORAL, BILATERAL THIN ACUTE SDH, FRACTURE GREATER WING OF SPHENOID, TEMPORAL BONE, MASTOID RIGHT SIDE ,DIFFUSE CEREBRAL EDEMA, BRUST LEFT TEMPORAL LOBE WITH MASS EFFECT, SAH, COMMINUTED FRACTURE HUMERUS LEFT, FRACTURE LEFT 4TH METATARSAL LEFT , FRACTURE LATERAL MALLEOLUS LEFT . SURGERY: LEFT SIDE FTP DECOMPRESSIVE CRANIECTOMY DONE ON 14/06/2022. Post operative period was uneventful. Orthopaedic consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to discharge against medical advice, so patient is being discharged under DAMA.

ARH1.0001167290	**Name**	Mr. ALETI LINGAIAH		
Patient Identifier	ARHIP56119		**Age**	59Yr 6Mth 24Days
Sex	Male		**Date of Admission**	10-Jun-2022
Date of Discharge				
MLC No				
Address	PALTHEM,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
Primary Consultant	Dr. KRISHNA CHAITANYA M --CARDIOLOGY			

CORONARY ARTERY DISEASE, OLD AWMI
S/P PTCA TO LAD [2018]

NOW ACS NSTEMI,

S/P PTCA TO RCA (2 STENTS) WITH 3V ASTRA [3.0 X 36 mm], 3 V ASTRA [3.0 X 12 mm] done on 14.06.2022

GOOD RESULT

C/o chest pain, SOB on exertion since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 56/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

Mr. ALETI LINGAIAH, 59 years old gentleman is a known case of CAD, S/P PTCA to LAD in 2018, now presented with chest pain, on evaluation diagnosed as ACS-NSTEMI. CAG done showed RCA 80% stenosis, RCA was revascularised with 2 stents. Good result. He is symptomatically better and haemodynamically stable, hence being discharged with following advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET-XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. RAMISTAR 1.25 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. FRUSELAC ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW ON 22/06/22 TO CARDIAC OPD WITH CBC, RP-2 REPORTS

ARH1.0001231990		**Name**	Mrs. K BHAGYA LAXMI		
	Patient Identifier	ARHIP56122		**Age**	75Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	11-Jun-2022
	Date of Discharge	12-Jun-2022			
	MLC No				
	Address	h no-7-4-18,vijayapuri,jagityal,Karimnagar,Telangana		**Ward/Bed No**	First Floor, HDU, Bed no:HDU 10
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
ACUTE GASTROENTERITIS;EVALUATION FOR ECG CHANGES (LBBB+VPL)PARADOXICAL SEPTAL MOTION;MILD AR/PAH SR,MODARATE LV SYSTOLIC DYSFUNCTION(EF-35%) CAG DONE ON(11/06/2022)-CAD MILD DISEASE. ADV-MEDICAL MANAGEMENT.	

ACUTE GASTROENTERITIS;EVALUATION FOR ECG CHANGES (LBBB+VPL)PARADOXICAL SEPTAL MOTION;MILD AR/PAH SR,MODARATE LV SYSTOLIC DYSFUNCTION(EF-35%)
CAG DONE ON(11/06/2022)-CAD MILD DISEASE.
ADV-MEDICAL MANAGEMENT.

C/o Sudden onset of vomitings 10 episodes and loose motions 10-12 episodes since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 109/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 75 years old female patient BHAGYA LAXMI came with c/o Sudden onset of vomitings 10 episodes and loose motions 10-12 episodes since 1 day. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS;EVALUATION FOR ECG CHANGES (LBBB+VPL)PARADOXICAL SEPTAL MOTION;MILD AR/PAH SR,MODARATE LV SYSTOLIC DYSFUNCTION(EF-35%), CAG DONE ON(11/06/2022)-CAD MILD DISEASE, ADV-MEDICAL MANAGEMENT. Patient was treated with antiplatelets, anticoagulation, antacids and other supportive measures. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. CONCOR 5 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. ECOSPRIN-AV 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. TAB. REDOTIL ONCE DAILY AT 8AM SOS
5. TAB. THYRONORM 12.5 MCG ONCE DAILY AT 8AM TO CONTINUE.
6. CAP. SPOROLAC DS **TWICE IN A DAY AT 8 AM 8 PM**
7. ORS SACHETS SOS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232035	**Name**	Mr. T RAJENDER SINGH		
	Patient Identifier	ARHIP56137	**Age**	42Yr 0Mth 5Days
	Sex	Male	**Date of Admission**	12-Jun-2022
	Date of Discharge	12-Jun-2022		
	MLC No			
	Address	Husnabad,Karimnagar,Telangana	**Ward/Bed No**	First Floor, Day Care, Bed no:DC 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

ATYPICAL CHEST PAIN,SINUS RHYTHUM,
SR,NORMAL LV FUNCTION,
CAG DONE ON (12/06/2022),
NORMAL CORONARIES,
PLAN; MEDICAL MANAGEMENT.
R/F;HYPERTENSION.

C/o Sudden onset of chest pain,
H/o mild sweating and mild SOB

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 64/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 42 years old male patient Mr. T RAJENDER SINGH came with c/o Sudden onset of chest pain, h/o mild sweating and mild SOB. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN,SINUS RHYTHUM, SR,NORMAL LV FUNCTION, CAG DONE ON (12/06/2022), NORMAL CORONARIES,
PLAN; MEDICAL MANAGEMENT. Patient was treated with antiplatelets, anticoagulation, antacids and other supportive measures. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7DAYS
5. SYP. GASTRACID 2tsp **TWICE IN A DAY AT 8 AM 8 PM**

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232084	**Name**	Mr. NALLAPU MAHENDAR			
	Patient Identifier	ARHIP56151		**Age**	27Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	13-Jun-2022
	Expired Date	17-Jun-2022			
	MLC No				
	Address	H NO-3-28,SOMANAPALLI,Karimnagar,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 2
	Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Consultant Nephrologist)--NEPHROLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
PARAQUAT POISONING	

Alleged history of consumption of paraquat poisoning around 125 ml at 1 p.m. on 13/06/2022

C/o throat pain , Shortness of breath

AT ADMISSION:

Patient c/c
PR: 130/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 27 years old male patient Mr. NALLAPU MAHENDAR presented with alleged history of consumption of paraquat poisoning around 125 ml at 1 p.m. on 13/06/2022, c/o throat pain , Shortness of breath. All necessary investigations were done and diagnosed as PARAQUAT POISONING. 2 sessions Hemoperfusion done, 1 Unit FFP transfusion given in view of blood vomitings, On 17/06/2022 at 03.00 AM patient had sudden cardiac arrest. CPR was initiated as per ACLS protocols, inspite of best effort return of spontaneous circulation could not be obtained, hence patient was declared as dead at 03.37 AM on 17/06/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO PARAQUAT POISONING

56078

ARH1.0001231925		**Name**	Mr. RAJENDER KATUKURI
Patient Identifier	ARHIP56078	**Age**	51Yr 0Mth 0Days
Sex	Male	**Date of Admission**	09-Jun-2022
Expired Date	09-Jun-2022		
MLC No			
Address	KOTHAPALLY,Karimnagar,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%	

C/o chest pain since 3 days

AT ADMISSION:
PR: 72/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 51 years old male patient RAJENDER KATUKURI came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support

was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 02.00 PM on 09/06/2022.

CAUSE OF DEATH

CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%

ARH1.0001232022		**Name**	Mrs. KONDLEPU LAXMI
Patient Identifier	ARHIP56130	**Age**	61Yr 5Mth 2Days
Sex	Female	**Date of Admission**	11-Jun-2022
Expired Date	13-Jun-2022		
MLC No			
Address	1-4-135/5, ARAVINDU NAGAR,JAGTIAL,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU13
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE ACUTE INFERIOR WALL MYOCARDIOL INFARCTION. MODERATE LV DYSFUNCTION EF 35%.	

C/o giddiness, profuse sweating with chest pain since 1 day

AT ADMISSION:
PR: 87/min
BP: 110/70mmHg
RS: BAE+

CVS: S1S2
RR: 20/min
SPO2: 98%
P/A: Soft

A 61 years old female patient Mrs. KONDLEPU LAXMI came with c/o giddiness, profuse sweating with chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ACUTE INFERIOR WALL MYOCARDIOL INFARCTION. MODERATE LV DYSFUNCTION EF 35%. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 06.40 PM on 13/06/2022.

CAUSE OF DEATH

CARDIORESPIRATORY ARREST DUE TO CORONARY ARTERY DISEASE ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION.NO TLT,SEVERE LV SYSTOLIC DYSFUNCTION .EF:30%

ARH1.0001231987		**Name**	Mrs. PRAMILA SUDDALA
Patient Identifier	ARHIP56118	**Age**	53Yr 0Mth 5Days
Sex	Female	**Date of Admission**	10-Jun-2022
Expired Date	15-Jun-2022		
MLC No			
Address	H.NO:1-114,APPANNAPET,PEDDAPALLY,Other,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU1

0

Primary Consultant	Dr. KRISHNA CHAITANYA M --CARDIOLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

⊟ Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type
CAD IPWSTEMI,AKI.	

C/o chest pain since 1 day

AT ADMISSION:
PR: 82/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 98%
P/A: Soft

A 53 years old female patient Mrs. PRAMILA SUDDALA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD IPWSTEMI,AKI. Poor prognosis explained to the patient attendants, suddenly patient unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 05.00 AM on 15/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST DUE TO CAD IPWSTEMI,AKI.

ARH1.0001232100		**Name**	Mr. GOPAL A		
	Patient Identifier	ARHIP56166		**Age**	56Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	14-Jun-2022
	Expired Date	17-Jun-2022			
	MLC No				
	Address	KMR,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU13
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CAD ACUTE AWMI.	

C/o chest pain a/w SOB, vomitings since 1 day

AT ADMISSION:
PR: 86/min
BP: 130/80mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 56 years old male patient Mr. GOPAL A came with c/o chest pain a/w SOB, vomitings since 1 day. All necessary investigations were done and diagnosed as CAD ACUTE AWMI. Poor prognosis explained to the patient attendants, suddenly patient unresponsive. INJ. Atropine and INJ.

ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.31 AM on 17/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST DUE TO CAD ACUTE AWMI

APJ1.0014502200		**Name**	Mr. Sreedhar Chittyala
Patient Identifier	ARHIP56138	**Age**	53Yr 7Mth 23Days
Sex	Male	**Date of Admission**	12-Jun-2022
Date of Discharge	12-Jun-2022		
MLC No			
Address	Hyderabad,Telangana	**Ward/Bed No**	First Floor, Day Care, Bed no:DC 1
Primary Consultant	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY	**Consultants**	
Surgeons	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY	**Anesthesiologists**	

⊟ Diagnosis

Diagnosis

Disease	Disease Type

CAD-CHEST PAIN
NORMAL LV SYSTOLIC FUNCTION EF-60%
CAG DONE ON (12/06/2022),
CAG-LAD AND RCA ECTATIC CONONARIES WITH SLOW FLOW,
PLAN;MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 53 years old male patient MR. SREEDHAR CHITTYALA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD-CHEST PAIN, NORMAL LV SYSTOLIC FUNCTION EF-60%, CAG DONE ON (12/06/2022), CAG-LAD AND RCA ECTATIC CONONARIES WITH SLOW FLOW, PLAN;MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001156760	**ARHIP56040**	Mrs. KAMALA RANI SARDAR | Female | 64Yr 0Mth 5Days	**MICU 7**	07-Jun-2022	Dr Chandra Shekar Sathineni

ACUTE EXACERBATION OF BRONCHIAL ASTHMA
RENAL INSUFFICIENCY

C/o shortness of breath grade 2 to 3 since 3 days associated with bilateral pedal oedema
Known case of bronchial asthma

AT ADMISSION:

Afebrile

PR: 115/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 60% on room air

P/A: Soft

A 64 years old female patient Mrs. KAMALA RANI SARDAR came with c/o shortness of breath grade 2 to 3 since 3 days associated with bilateral pedal oedema. Known case of bronchial asthma. All necessary investigations were done and diagnosed as ACUTE EXACERBATION OF BRONCHIAL ASTHMA, RENAL INSUFFICIENCY.
Patient was on NIV support in view of respiratory acidosis. Managed conservatively. Pulmonologist & Nephrologist consultations taken and advise followed . Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:
---

1) TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 5 DAYS.

4) TAB. RENOSAVE ONCE DAILY AT 2PM FOR 10 DAYS

5) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

6) NEBULIZATION WITH DUOLIN, BUDECORT

7) TAB. BILAHENZ-M ONCE DAILY AT 8PM FOR 10 DAYS

8) TAB. PREDMET 8 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS, THEN

TAB. PREDMET 8 MG ONCE DAILY AT 2PM FOR 5 DAYS AND STOP

9) TAB. PIDOTIMMUNE 800 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232101		**Name**	Mrs. RAJAMMA BONGANI		
	Patient Identifier	ARHIP56170		**Age**	63Yr 0Mth 4Days
	Sex	Female		**Date of Admission**	14-Jun-2022
	Date of Discharge				
	MLC No				
	Address	1-85/1 ENDAPALLY,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, AWMI

RIGHT MONO HEMIPARESIS WITH APHASIA

C/o chest pain a/w SOB since 3-4 days

K/c/o T2DM, HTN

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old female patient Mrs. RAJAMMA BONGANI came with c/o chest pain a/w SOB since 3-4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, RIGHT MONO HEMIPARESIS WITH APHASIA. Managed conservatively. Neurophysician consultation taken and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CONCOR COR 1.25 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB: FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
6. INJ HUMAN INSULATARD S/C 12 Units AT 8AM AND 8PM CONTINUE
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001232134			**Name**	Mrs. N PUSHPALATHA	
Patient Identifier	ARHIP56175			**Age**	65Yr 0Mth 1Days
Sex	Female			**Date of Admission**	14-Jun-2022
Expired Date	15-Jun-2022				
MLC No					
Address	KARIMNAGAR,Karimnagar,Telangana			**Ward/Bed No**	First

Floor, MICU, Bed no:MICU 12

Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Consultant Nephrologist)--NEPHROLOGY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

SEPTIC SHOCK WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME

Fever with shortness of breath and generalised weakness since 2 days

Known case of hypertension, diabetes mellitus

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old female patient PUSHPALATHA came with c/o fever with shortness of breath and generalised weakness since 2 days. All necessary investigations were done and diagnosed as SEPTIC SHOCK WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME. Poor prognosis explained to the patient attendants, suddenly patient unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.39 PM on 15/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST DUE TO SEPTIC SHOCK WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME

56048
Sunitha

ACUTE EXACERBATION OF BRONCHIAL ASTHMA
ACUTE HEPATITIS
HYPOKALAEMIA
IRON DEFICIENCY ANAEMIA
PROBABLE STRESS CARDIOMYOPATHY

C/o progressive dyspnoea, body ache since 7 days

Known case of bronchial asthma

AT ADMISSION:

Patient was intubated
PR: 112/min

BP: 120/70mmHg

RS: Bilateral extensive wheeze present

A 39 years old female patient SUNITHA presented with the above-mentioned complaints patient was diagnosed to have acute exacerbation of bronchial asthma. In view of severe type II respiratory failure patient was intubated. The patient was started on broad spectrum antibiotics along with METHYLPREDNISOLONE 60 mg IV 1-0-1. After 2 days of hospitalisation patient was extubated as the respiratory parameters improved. 24 hours post extubation patient develop severe type II respiratory failure again and was drowsy hence patient was re-intubated. 48 hours after re intubation patient was extubated. Patient was continued on NIV support throughout the hospital stay for the next 4 days of hospitalisation. 2D echo was done for the patient which showed severe LV dysfunction, Cardiologist consultation was taken and was advised similar medication suspecting stress cardiomyopathy. Blood culture and urine culture was sterile. Daily monitoring of electrolytes and creatinine was done. As patient had low haemoglobin 1 packed red cells blood transfusion was done. ANA profile for the patient was negative. Patient had thrombocytopenia which has now resolved. Patient had disseminated intravascular coagulation which is now resolved. Initially patient had acute hepatitis which has now resolved. Now the patient is haemodynamically stable and is maintaining saturation on room air and is hence being discharged with home BI-PAP at night and the following medications.

DISCHARGE MEDICATION:

---

1) TAB. GEROZ- LP ONCE DAILY AT 2PM FOR 10 DAYS

2) NEBULIZATION WITH DUOLIN EVERY 6th hrly FOR 10 DAYS

3) TAB. PAN 40 MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

4) TAB. MONTEK-LC ONCE DAILY AT 8PM FOR 10 DAYS

5) SYP. ASCORYL-D 10 ml THRICE DAILY AT 8AM 2PM 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS IN GENERAL MEDICINE OPD WITH CBP, RP-II REPORTS

56214 hameed

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

MILD LV DYSFUNCTION [EF-45%]

R/F : ALCOHOLIC

CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old male patient G. RAJU came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-

45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232254		**Name**	Mr. M D HAMEED	
Patient Identifier	ARHIP56214		**Age**	34Yr 0Mth 1Days
Sex	Male		**Date of Admission**	17-Jun-2022
Date of Discharge				
MLC No				
Address	JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATYPICAL CHEST PAIN
MILD MR/ TR/ PAH,
CORONARY ANGIOGRAM (17/06/2022) -CAD-Mild disease (proximal LAD ectasia present)

ADV: MEDICAL MANAGEMENT

C/o chest pain since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 34 years old male patient Mr. M D HAMEED came with c/o chest pain since 1 month. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, MILD MR/ TR/ PAH, CORONARY ANGIOGRAM (17/06/2022) -CAD-Mild disease (proximal LAD ectasia present), ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231887		**Name**	Mr. MUTHYALA SATHAIAH		
	Patient Identifier	ARHIP56071		**Age**	70Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	08-Jun-2022
	Expired Date	09-Jun-2022			
	MLC No				
	Address	maddunoor,Karimnagar,Telangana		**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME6
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Diseas	Disease

e	Type

CAD-ACUTE ANTERIOR WALL ST ELEVATED MI AND DKA.

C/o chest pain a/w SOB, sweatings since 1 day

AT ADMISSION:
PR: 125/min
BP: Not recordable
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 96%
P/A: Soft

A 70 years old male patient Mr. MUTHYALA SATHAIAH came with c/o chest pain a/w SOB, sweatings since 1 day. All necessary investigations were done and diagnosed as CAD-ACUTE ANTERIOR WALL ST ELEVATED MI AND DKA. Poor prognosis explained to the patient attendants, suddenly patient unresponsive. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.27 AM on 09/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST DUE TO CAD-ACUTE ANTERIOR WALL ST ELEVATED MI AND DKA.

ARH1.0001084465		**Name**	Mr. VENKATESH KAMINWAR		
	Patient Identifier	ARHIP56221		**Age**	62Yr 7Mth 7Days
	Sex	Male		**Date of Admission**	18-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KARIMNAGAR.,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 3
	Primary Consultant	Dr. SURESH GOUD S(MS,			

PHIMOSIS
SURGERY: CIRCUMCISSION DONE ON 18/06/2022

C/o difficulty in micturition since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

PR-81/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 62 yrs old male patient VENKATESH KAMINWAR came with c/o difficulty in micturition since 1 month. All necessary investigations done and diagnosed as PHIMOSIS, SURGERY: CIRCUMCISSION DONE ON 18/06/2022. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: AUGMENTIN 625 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DROLGA TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: PAN 40 MG ONCE DAILY AT 7AM FOR 5 DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS.
5. SYP. K-CIT 10 ml TWICE DAILY AT 8AM, 8PM

Review after 7 days in Urology OPD.

ARH1.0001226812		**Name**	Mr. MEDICHELIMALA RAJAIAH
Patient Identifier	ARHIP55934	**Age**	50Yr 11Mth 29Days
Sex	Male	**Date of Admission**	30-May-2022
Date of Discharge			
MLC No			
Address	2-49 AMBALPUR SHANKARAPATNAM 9704704298,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 4
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

PCA INFARCT WITH SEPTIC SHOCK

C/o Giddiness since 1 day

Known case of hypertension diabetic mellitus

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 50 yr old male patient Mr. MEDICHELIMALA RAJAIAH came with c/o giddiness since 1 day. All necessary investigations done and diagnosed as CVA PCI STROKE, LEFT HEMIPLEGIA WITH SEPTIC SHOCK. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice. Managed with antibiotics and antiplatelets and GCS poor. Neurosurgeon consultation taken. Case of no surgical intervention patient was detoriated and elective intubation done for prevention of aspiration and general Physician Consultation taken. Patient mild clinically improved and he was on breath and without O2 he monitoring on T- piece. Then extubated on 06/06/22 at 1 pm and patient was desaturating with 8 Ltr of 2 again re intubated on 06/06/22 at 2 p.m. ENT consultation done and plan for tracheostomy. Tracheostomy done on 10/06/22 patient on mechanical ventilator. Managed conservatively. Patient clinically improved. Now patient is stable hence patient is being discharged with required medication and advice.

Discharge Medication:

1. TAB: CLOPILET 75 MG ONCE DAILY AT 2 PM TO CONTINUE
2. TAB: STORVAS 40 MG ONCE DAILY AT 8 PM TO CONTINUE
3. TAB: BEPLEX FORTE ONCE DAILY AT 2 PM TO CONTINUE
4. TAB: PAN 40 MG ONCE DAILY AT 7 AM BBF FOR 11 DAYS

Review after 10 days in DR NIKHIL GOLI SIR OPD.

ARH1.0001146025		**Name**	Mr. RAMANCHA RAJKUMAR
Patient Identifier	ARHIP56217	**Age**	29Yr 7Mth 29Days
Sex	Male	**Date of Admission**	18-Jun-2022
Date of Discharge			
MLC No			
Address	NTPC,Ramagundam,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:117 B
Primary Consultant	DR. SRI KARAN UDDESH		

ACUTE ABDOMINAL PAIN
SECONDARY TO TRAUMA LEFT ILIAC REGION

C/o Pain in the left iliac region, following trauma to the region

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 29 years old male patient Mr. RAMANCHA RAJKUMAR came with above mentioned complaints. Patient diagnosed as ACUTE ABDOMINAL PAIN, SECONDARY TO TRAUMA LEFT ILIAC REGION. Treated with Inj Tramadol, Pan, Zofer. Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. CHYMORAL FORTE THRICE DAILY AT 8AM 2PM & 8PM FOR 7 DAYS

2) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

3) TAB. ULTRACET **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001104540		**Name**	Mrs. RAJESHWARI P
Patient Identifier	ARHIP56139	**Age**	76Yr 1Mth 15Days
Sex	Female	**Date of Admission**	12-Jun-2022
Date of Discharge			
MLC No			
Address	sulthanabad,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:106 A
Primary Consultant	Dr. RAMCHANDER TORREM(MD		

RIGHT URETERIC CALCULUS

SURGERY: RIGHT URSL + DJ STENTING ON 15/06/2022

C/o right flank pain, burning micturition, nausea since 15 days

K/c/o HTN

ON ADMISSION

Patient c/c

Afebrile

PR-82/min

BP-120/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 76 years old female patient Mrs. RAJESHWARI presented to hospital with c/o right flank pain, burning micturition, nausea since 15 days. All necessary investigations were done and diagnosed as RIGHT URETERIC CALCULUS, Urologist consultation taken and advised surgery, RIGHT URSL + DJ STENTING ON 15/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB: QCEFOR 250 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: UBLIFE ONCE DAILY AT 2PM FOR 10 DAYS
3. TAB: MULTI-8 ONCE DAILY AT 2PM FOR 10 DAYS
4. TAB: CARTBIND **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
5. SYP. LACTIHEP 15 ml ONCE DAILY AT 8PM FOR 7 DAYS.
6. TAB: PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO NEPHROLOGY & UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001232144	**Name**	Mr. NAGELLA JHONWESLEY	

Patient Identifier	ARHIP56178	**Age**	72Yr 0Mth 5Days
Sex	Male	**Date of Admission**	14-Jun-2022
Expired Date	19-Jun-2022		
MLC No			
Address	41-42,RAMAKRISHNAPUR, MANDAMARRI,MANCHERAIL,Karimnagar,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 5
Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	**Consultants**	
Surgeons		**Anesthesiologists**	

Cause of Death

Cause of Death

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type

TRAUMATIC BRAIN INJURY DIFFUSE SUBARACHNOID HEMORRHAGE.

Alleged to have sustained injury due to hit by Tractor while going on 2 wheeler on 13/06/2022 around 10.30 AM

Patient unresponsive state, vomiting, ENT Bleeding+

k/c/o HTN, T2DM

AT ADMISSION:

Patient unresponsive

PR: 96/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 95%

P/A: Soft,

GCS- E1,VT,M1

A 72 years old male patient Mr. NAGELLA JHONWESLEY came with alleged to have sustained injury due to hit by Tractor while going on 2 wheeler, patient unresponsive state, vomiting, ENT Bleeding+ . All necessary investigations were done and diagnosed as TRAUMATIC BRAIN INJURY, DIFFUSE SUBARACHNOID HEMORRHAGE. Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. CPR was initiated as per ACLS protocols, continued for 5 cycles but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.07 pm on 19/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO TRAUMATIC BRAIN INJURY DIFFUSE SUBARACHNOID HEMORRHAGE

ARH1.0001232147		**Name**	Mr. SRINIVAS RAO RACHAMADGU		
	Patient Identifier	ARHIP56183		**Age**	51Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	15-Jun-2022
	Date of Discharge				
	MLC No				
	Address	2-40/1 THANDRIYALA,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
	Primary Consultant	Dr. KRISHNA CHAITANYA M			

CORONARY ARTERY DISEASE, AWSTEMI, EPISODE OF VT

S/P PRIMARY PTCA TO THROMBOTIC TOTAL OCCLUSION

SEVERE LV DYSFUNCTION, [LVEF- 30%]
AW/AS AKINETIC CONTROLLED HF, SR

C/o chest pain was evaluated at Local Hospital, diagnosed to have AWSTMI and had an episode of documented VT recovered , spontaneously reverted. He was referred here for further management

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Mr. SRINIVAS RAO RACHAMADGU , 51 years old gentleman presented with history of chest pain was evaluated at Local Hospital, diagnosed to have AWSTMI and had an episode of documented VT recovered , spontaneously reverted. He was referred here for further management. He was taken up for primary PTCA. Coronary angiogram showed mid LAD thrombotic total occlusion. Primary PTCA to mid LAD done. TIMI-III flow. Good result. During the course of hospitalisation his sugars were controlled and renal dysfunction was managed with IV fluids and Reno-protective medication in consultation with Nephrologist and Physician. He was monitored for VT/VF episodes. His B. blockers and ivabradline dosages were adjusted. He was haemodynamically stable and symptomatically better. Hence being discharged for follow up with the following advice.

DISCHARGE MEDICATION:

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1. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
4. TAB. FLAVEDON MR 35MG **THRICE IN A DAY AT 8 AM 2PM & 8 PM** TO CONTINUE.
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. SOBINIX 500MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
8. TAB. RENOSAVE **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
9. TAB. FRUSELAC-DS **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
10. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.

DIABETIC DIET AS ADVISED NUTRITIONIST
DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW ON 28/06/2022 (TUESDAY) WITH CBC, RP-II, FCP & ECG REPORTS TO CARDIAC OPD

ARH1.0001232045		**Name**	Mr. N SRIDHAR
Patient Identifier	ARHIP56142	**Age**	35Yr 0Mth 7Days
Sex	Male	**Date of Admission**	13-Jun-2022
Date of Discharge			
MLC No			
Address	ITKAYALA RAIKAL JAGITIAL,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:118 A
Primary Consultant	Dr Chandra Shekar Sathineni		

ACUTE PANCREATITIS

C/o constipation, multiple episodes of vomitings, generalised weakness since 1 day
History of epigastric pain since 3-4 days
Known case of chronic alcoholic

AT ADMISSION:

Afebrile

PR: 85/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft,

A 35 years old male patient SRIDHAR came with c/o constipation, multiple episodes of vomitings, generalised weakness since 1 day, history of epigastric pain since 3-4 days, Known case of chronic alcoholic. All necessary investigations were done and diagnosed as ACUTE PANCREATITIS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. FPM-ACT TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
3. TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
4. TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS
5. GLUTUP SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 10 DAYS.

Review after 7 days in General Medicine OPD.

ARH1.0001231527		**Name**	Mr. SUDHEER KALLEPALLY		
	Patient Identifier	ARHIP56154		**Age**	40Yr 0Mth 21Days
	Sex	Male		**Date of Admission**	13-Jun-2022
	Date of Discharge				
	MLC No				
	Address	1-84,paddapalli,karimnagr,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:123 B
	Primary Consultant	Dr. RAMCHANDER TORREM(			

AKI

C/o fever, dysurea, generalized weakness since 2 days

AT ADMISSION:

PR: 84/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old male patient Mr. SUDHEER KALLEPALLY came with c/o fever, dysurea, generalized weakness since 2 days. All necessary investigations were done and diagnosed as AKI. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. SOBINIX-DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. METOZ 5 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CARDIVAS 12.5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MOXOVAS 0.3 MG **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
7. TAB. ZEROZ LP **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
8. TAB. WYSOLONE 10 MG ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. ZOLFRESH 5 MG ONCE DAILY AT 8PM TO CONTINUE.
10. TAB. PANTOCID 40 MG ONCE DAILY AT 7 AM BBF FOR 7 DAYS

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001186579		**Name**	Mrs. L MAMATHA		
	Patient Identifier	ARHIP56157		**Age**	29Yr 1Mth 17Days
	Sex	Female		**Date of Admission**	13-Jun-2022
	Date of Discharge				
	MLC No				
	Address	NAGNOOR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:108 A
	Primary Consultant	Dr. RAMCHANDER TORREM			

IGA NEPHROPATHY
CGN-CKD

C/o Vomiting, nausea since 2 days

Known case of IGA NEPHROPATHY, CGN-CKD

S/P AV fistula not working

AT ADMISSION:

PR: 80/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 29 years old female patient Mrs. MAMATHA came with c/o Vomiting, nausea since 2 days. All necessary investigations were done and diagnosed as IGA NEPHROPATHY, CGN-CKD. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. SOBINIX-DS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ZEROZ LP **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
4. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CALCI CZ ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. PROLOMET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
8. SYP. LACTIHEP 2 tsp ONCE DAILY AT 9 P.M.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001232218		**Name**	Mrs. BHOODEVI K
Patient Identifier	ARHIP56203	**Age**	56Yr 0Mth 4Days
Sex	Female	**Date of Admission**	16-Jun-2022
Date of Discharge			
MLC No			
Address	kothapalli (haveli),Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:103 C
Primary Consultant	Dr. RAMCHANDER TORREM(MD (General		

AKI
DIABETIC MELLITUS
HYPERTENSION

C/o Shortness of breath, chest pain, bilateral pedal oedema since 2 days

AT ADMISSION:

PR: 80/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 56 years old female patient Mrs. BHOODEVI K came with c/o shortness of breath, chest pain, bilateral pedal oedema since 2 days. All necessary investigations were done and diagnosed as AKI, DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. FAROALFA 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. SOBINIX-DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSA GOLD MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RECLIDE XR 30 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001232171		**Name**	Mr. CHENNURI PULLAIAH		
	Patient Identifier	ARHIP56186		**Age**	70Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	15-Jun-2022
	Date of Discharge				
	MLC No				
	Address	18-1-95, ADDAGUNTAPALLI, GODAVARIKANI,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:122 B
	Primary Consultant	DR. SRI KARAN UDDESH --			

URINARY TRACT INFECTION
PARKINSON DISEASE

C/o fever with chills, burning micturition since 3 days

Chronic alcoholism, diabetic mellitus

AT ADMISSION:

PR: 100/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft,

A 70 years old male patient Mr. CHENNURI PULLAIAH came with above mentioned complaints, patient presented with the above-mentioned complaints patient was diagnosed to have urinary tract infection and was started on INJ. LEVOFLOXACIN and other supportive treatment. On the second day of hospitalisation the patient was observed to have a pill rolling tremor and was having history of bradykinesia and on examination had mild cogwheel rigidity. An MRI brain was done which revealed lacunar infarcts, report has been enclosed. The patient was symptomatically better and is hence being discharged with following advice.

DISCHARGE MEDICATION:

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1) TAB. SYNDOPA PLUS ½ TAB THRICE DAILY AT 8AM 2PM & 8PM FOR 7 DAYS

2) TAB. THIAMINE 100 MG ONCE DAILY AT 2PM FOR 7 DAYS

3) TAB. NEURIT CD3 ONCE DAILY AT 8AM FOR 7 DAYS

4) TAB. OXAZEPAM 15 MG ONCE DAILY AT 8PM FOR 7 DAYS

5) SYP. LACTIFIBRE 15 ml ONCE DAILY AT 9 P.M.

6) TAB. TELMA 20 MG ONCE DAILY AT 8AM FOR 7 DAYS

7) TAB. VELDA-M 50/1000 **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

8) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232117		**Name**	Mr. BHOOMAIAH G
Patient Identifier	ARHIP56187	**Age**	62Yr 0Mth 6Days
Sex	Male	**Date of Admission**	15-Jun-2022
Date of Discharge			
MLC No			
Address	THEEGALAGUTTAPALLI,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Male General Ward, Bed no:GW 22
Primary Consultant	Dr. KRISHNA CHAITANYA M --CARDIOLOGY		

CORONARY ARTERY DISEASE, AWMI, FAIR LV FUNCTION, NO HF, SR

LAD MID 95% STENOSIS

PTCA TO LAD [2 STENTS]

GOOD RESULT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 90/50mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 62 years old Mr. BHOOMAIAH presented with history of chest pain was evaluated and coronary angiogram done showed proximal to mid long segment LAD disease with maximum severity of 95% stenosis. PTCA to LAD with 2 stents [Metafor 3.0 x 16 mm, Metafor 2.75 x 37 mm] done. Good result. His medication were optimized. He is symptomatically better and haemodynamically stable, hence being discharged with following advice.

DISCHARGE MEDICATION:

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1. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. NIKORAN 5 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. TAB. OROFER XT ONCE DAILY AT 8AM TO CONTINUE.

DIABETIC DIET AS ADVISED NUTRITIONIST
DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW ON 28/06/2022 (TUESDAY) WITH CBC, RP-II & ECG REPORTS TO CARDIAC OPD

ARH1.0001232156		**Name**	Mr. GARGULA CHANDRAREDDY		
	Patient Identifier	ARHIP56184		**Age**	64Yr 5Mth 5Days
	Sex	Male		**Date of Admission**	15-Jun-2022
	Date of Discharge				
	MLC No				
	Address	1-66, RAMANNAPET,Sircilla,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 12
	Primary Consultant	Dr. KRISHNA CHAITANYA			

CORONARY ARTERY DISEASE, AWMI, MILD LV DYSFUNCTION,

S/P: PTCA TO LAD OSTIAL [4 X 16 mm stent]

NO HF, SR

C/o chest pain since 4 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 64 years old Mr. GARGULA CHANDRAREDDY patient presented with complaint of chest pain ECG showed AW ST-T changes. Coronary angiogram done which showed ostial LAD 80% stenosis PTCA to LAD done with 4 x 16 mm stent. He was symptom free post procedure. He is symptomatically better. Hence being discharged with following advice.

DISCHARGE MEDICATION:

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1. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.

DIABETIC DIET AS ADVISED NUTRITIONIST
DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW ON 28/06/2022 (TUESDAY) WITH CBC, RP-II & ECG REPORTS TO CARDIAC OPD

ARH1.0001232125		**Name**	Mr. M VENKAIAH
Patient Identifier	ARHIP56180	**Age**	72Yr 0Mth 6Days
Sex	Male	**Date of Admission**	14-Jun-2022
Date of Discharge			
MLC No			
Address	KAGAZNAGAR,Telangana	**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 20
Primary Consultant	Dr. SURESH GOUD		

RIGHT RENAL CALCULUS
RIGHT PCNL+DJ STENTING DONE ON 15.06.2022

C/o Right loin pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 72 yrs old male patient VENKAIAH came to the hospital with c/o right loin pain, burning micturition since 7 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PCNL+DJ STENTING DONE ON 15.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient is being discharged in haemodynamically stable condition with required medication and advice.
Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

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1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001128973		**Name**	Mr. PARKALA ANJAIAH		
	Patient Identifier	ARHIP56239		**Age**	46Yr 2Mth 3Days
	Sex	Male		**Date of Admission**	20-Jun-2022
	Date of Discharge				
	MLC No				
	Address	THIPPAPURAM,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

ATYPICAL CHEST PAIN WITH ECG CHANGES
CORONARY ANGIOGRAM (20/06/22) PATENT STENT IN LAD
K/C/O CAD -AWMI PRIMARY PTCA TO LAD ON 17/04/2017
R/F HYPERTENSION
ADV: MEDICAL MANAGEMENT

C/o Chest pain radiating to back since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 46 years old male patient PARKALA ANJAIAH came with c/o Chest pain radiating to back since 2 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES
CORONARY ANGIOGRAM (20/06/22) PATENT STENT IN LAD, K/C/O CAD -AWMI PRIMARY PTCA TO LAD ON 17/04/2017, R/F HYPERTENSION, ADV: MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ROSAGOLD ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PROLOMET R 25 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PAN-D 40 MG ONCE IN A DAY AT 7 A.M. BBF FOR 10 DAYS
4. SYP. POTKLOR 10 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 2 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232146	**Name**	Mr. SWAMIDAS MYSDADARI			
	Patient Identifier	ARHIP56179		**Age**	52Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	14-Jun-2022
	Date of Discharge				
	MLC No				
	Address	5-88 GOLLAPALLY,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW17
	Primary Consultant	Dr. RAMCHANDER TORREM(MD			

CHRONIC KIDNEY DISEASE

C/o Shortness of breath, swelling of feet, decreased appetite

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient Mr. SWAMIDAS MYSDADARI came with c/o Shortness of breath, swelling of feet, decreased appetite. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, 4 sessions of haemodialysis done . Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. CEFURAZ-CV TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
4. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. METOZ ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CALCI-OZ ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS IN NEPHROLOGY OPD

ARH1.0001232054		**Name**	Mr. THOOM RAMAIAH
Patient Identifier	ARHIP56149	**Age**	76Yr 5Mth 7Days
Sex	Male	**Date of Admission**	13-Jun-2022
Date of Discharge			
MLC No			
Address	1-78, WALLAMPAHAD,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 14
Primary Consultant	Dr. Iftekarali (MS		

INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT

SURGERY: AMP LEFT HIP DONE ON 15/06/2022

Alleged to have sustained injury due to slip and fall at home, sustained injury to left leg

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-84/min
BP-120/80mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-99%

A 76 years old male patient Mr. THOOM RAMAIAH came with alleged to have sustained injury due to slip and fall at home, sustained injury to left leg . All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT, SURGERY: AMP LEFT HIP DONE ON 15/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. TROVFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN 75MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYCID—RD ONCE DAILY AT 2PM FOR 11 DAYS.
4. TAB. OCTOCAL ONCE DAILY AT 2PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001231831		**Name**	Mr. R MONDAIAH
Patient Identifier	ARHIP56136	**Age**	55Yr 0Mth 12Days
Sex	Male	**Date of Admission**	12-Jun-2022
Date of Discharge			
MLC No			
Address	marripelli,vemulawada,Sircilla,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 5
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P AWMI+DM+HTN

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE ON 15/06/2022.

C/o retrosternal chest pain a/w sweating since 1 day

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 55 years old male patient Mr. MONDAIAH presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ S/P AWMI+DM+HTN, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE ON 15/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, NO PE/CLOT/VEG, EF-55%

BMI is _____ kg/m2.

Sr. Creatinine report on 16.06.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. CARDARONE 200 MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.

5) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. ZETAGLIM MV2 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

9) TAB. EOSHINE MR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

10) TAB. BACLOFSIN THRICE **IN A DAY AT 8 AM 2PM 8 PM** TO CONTINUE.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001230547		**Name**	Mr. SATHIAIAH BURRA
Patient Identifier	ARHIP56208	**Age**	69Yr 1Mth 16Days
Sex	Male	**Date of Admission**	17-Jun-2022
Date of Discharge			
MLC No			
Address	TANGALLAPALLY, KOHEDA,,Siddipet,Telangana	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
Primary Consultant	DR. SANJAY KUMAR KAMINWAR		

ACUTE LEFT PCA INFARCTION
INFERIOR WALL MI
AKI

C/o drooping of left eyelid
H/o dyspnea, vomiting, fever since 4 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 69 years old male patient Mr. SATHIAIAH BURRA came with c/o drooping of left eyelid, h/o dyspnea, vomiting, fever since 4 days. All necessary investigations were done and diagnosed as ACUTE LEFT PCA INFARCTION, INFERIOR WALL MI, AKI. Managed conservatively. Cardiologist consultation taken and advised, coronary angiogram, CAG not done due to increase in creatinine. Nephrolgist consultation taken and advice followed. Poor prognosis explained to the patient attendants, Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

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1) TAB. PREVA AS 75 MG ONCE DAILY AT 2PM FOR 7 DAYS

2) TAB. ATCOR 40 MG ONCE DAILY AT 9PM FOR 7 DAYS

3) TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

4) TAB. CUDCE **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

5) TAB. FEBUGET ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN DR SANJAY KUMAR SIR OPD

ARH1.0001232355		**Name**	Mr. VENU GOPAL KORE
Patient Identifier	ARHIP56256	**Age**	35Yr 0Mth 1Days
Sex	Male	**Date of Admission**	20-Jun-2022
Date of Discharge			
MLC No			
Address	KALYANIKHANI,MANDAMARRI,MANCHERIAL,Adilabad(Adilabad),Telangana	**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 1
Primary Consultant	Dr. KRISHNA CHAITANYA M --		

S

CORONARY ARTERY DISEASE- UNSTABLE ANGINA.
CORONARY ANGIOGRAM DONE ON 20/06/2022- CAD-LAD –ECTATIC CORONARIES WITH SLOW FLOW

PLAN:MEDICAL MANAGEMENT

C/o left sided chest pain since 1 day

H/o numbness and tingling sensation in both upper limbs

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 58/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 35 years old male patient Mr. VENU GOPAL KORE came with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- UNSTABLE ANGINA.
CORONARY ANGIOGRAM DONE ON 20/06/2022- CAD-LAD –ECTATIC CORONARIES WITH SLOW FLOW, PLAN:MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN-AV 75 MG/10 ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. FLAVEDAN MR 35MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
4. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
5. TAB. ANXIT 0.25 MG ONCE DAILY AT 9 PM FOR 10 DAYS.

REVIEW ON 21/06/2022 TO CARDIAC OPD

ARH1.0001232303		**Name**	Mrs. NARSU BAI GONE		
	Patient Identifier	ARHIP56238		**Age**	102Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	20-Jun-2022
	Date of Discharge				
	MLC No				
	Address	BOYAWADA, KORUTLA, JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
	Primary Consultant	Dr Chandra Shekar Sathineni			

UPPER GI BLEED
? APD
ANAEMIA

Patient presented with c/o fever since 1 day a/w blood vomitings 6 episodes,

AT ADMISSION:

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 102 years old female patient Mrs. NARSU BAI GONE came with c/o fever since 1 day associated with blood vomitings 6 episodes. All necessary investigations were done and diagnosed as UPPER GI BLEED, ? APD, ANAEMIA. Managed conservatively. 2 units of PCV transfusion given in view of anaemia. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001232185		**Name**	Mrs. PRAMEELA ELUGAM
Patient Identifier	ARHIP56197	**Age**	56Yr 0Mth 6Days
Sex	Female	**Date of Admission**	16-Jun-2022
Date of Discharge			
MLC No			
Address	2-7-1099 F CLONY,Adilabad(Adilabad),Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU1 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI

MODERATE LV DYSFUNCTION, EF-37%

CORONARY ANGIOGRAM DONE ON 18/06/2022 – CAD-SVD (RCA)

PTCA+DES TO RCA 2 STENTS WITH 3.0 X 19 MM METAFOR TO MID RCA, 3.0 X 13 MM METAFOR TO PROXIMAL RCA DONE ON 16/10/2021

C/o Retrosternal chest pain radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 56years old female patient Mrs. PRAMEELA ELUGAM came with c/o retrosternal chest pain radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV DYSFUNCTION, EF-37%, CORONARY ANGIOGRAM DONE ON 18/06/2022 – CAD-SVD (RCA), PTCA+DES TO RCA 2 STENTS WITH 3.0 X 19 MM METAFOR TO MID RCA, 3.0 X 13 MM METAFOR TO PROXIMAL RCA DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. ELTROXIN 25 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232186		**Name**	Mr. D GANGAIAH
Patient Identifier	ARHIP56198	**Age**	72Yr 0Mth 5Days
Sex	Male	**Date of Admission**	16-Jun-2022
Date of Discharge			
MLC No			
Address	CHAMANAPALLI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 9
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, AWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 18/06/2022 – CAD-SVD (LAD) & RCA Ectesia

PTCA+DES TO LAD WITH 3.0 X 16 MM METAFOR DONE ON 18/06/2022
R/F: DENOVO HTN

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 102/min

BP: 160/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 72years old male patient Mr. GANGAIAH came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: DENOVO HTN, CORONARY ANGIOGRAM DONE ON 18/06/2022 – CAD-SVD (LAD) & RCA Ectesia, PTCA+DES TO LAD WITH 3.0 X 16 MM METAFOR DONE ON 18/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. RAMISTAR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

7) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

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ARH1.0001178468		**Name**	Mr. CHENNAMANENI SUGUNAKAR RAO
Patient Identifier	ARHIP56241	**Age**	55Yr 2Mth 1Days
Sex	Male	**Date of Admission**	20-Jun-2022
Date of Discharge			
MLC No			
Address	9-4-222,SRINAGAR COLONY,SAPTHAGIRI COLONY,Karimnagar,Telangana	**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 3
Primary Consultant	Dr. GOUTHAM ROY (MS		

GRADE-III INTERNAL HEMORRHOIDS
SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 20/06/2022

C/o pain and bleeding per rectum since 10 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 55 yrs old male patient Mr. CHENNAMANENI SUGUNAKAR RAO came with c/o pain and bleeding per rectum since 10 days. All necessary investigations done and diagnosed as GRADE-III INTERNAL HEMORRHOIDS, SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 20/06/2022. Findings: Multiple internal hemorrhoids noted @ 3'O, 7'O & 11'O clock in position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
4. XYLOCAINE JELLY EVERY 4th hrly
5. SITZ BATH
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001232256		**Name**	Mr. NARAYANA KONDAPALLI
Patient Identifier	ARHIP56216	**Age**	47Yr 0Mth 4Days
Sex	Male	**Date of Admission**	18-Jun-2022
Date of Discharge			
MLC No			
Address	6-53/3 CHEERAL VANCHA,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU13
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE , ACUTE AWMI

MODERATE LV DYSFUNCTION, EF-40%

S/P CORONARY ANGIOGRAM DONE ON 20/06/2022 – CAD-DVD [LAD, RCA]

PLAN CABG.

R/F HTN, T2DM

C/o Retrosternal chest pain, non radiating since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 47 years old male patient Mr. NARAYANA KONDAPALLI came with c/o retrosternal chest pain, non radiating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWMI, MODERATE LV DYSFUNCTION, EF-40%, S/P CORONARY ANGIOGRAM DONE ON 20/06/2022 – CAD-DVD [LAD, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. AMARYL 1 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001232085		**Name**	Ms. D VARSHINI
Patient Identifier	ARHIP56209	**Age**	9Yr 0Mth 8Days
Sex	Female	**Date of Admission**	17-Jun-2022
Date of Discharge			
MLC No			
Address	KORUTLA,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 6
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ACHD, OS-ASD, L - R SHUNT

S/P DEVICE CLOSURE DONE ON 20/06/2022

DEVICE MALALINED, NO FLOW ACROSS THE SEPTUM

PLAN: SURGICAL CLOSURE OF ASD

C/o left sided chest pain since 3 months

H/o giddiness

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 9 years old female patient Ms. D. VARSHINI came with c/o left sided chest pain since 3 months. All necessary investigations were done and diagnosed as ACHD, OS-ASD, L - R SHUNT, S/P DEVICE CLOSURE DONE ON 20/06/2022, DEVICE MALALINED, NO FLOW ACROSS THE SEPTUM, PLAN: SURGICAL CLOSURE OF ASD. Patient is being discharged in hemodynamically stable condition with required medication and advise.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001232257		**Name**	Mrs. A VAJARAMMA
Patient Identifier	ARHIP56218	**Age**	81Yr 0Mth 3Days
Sex	Female	**Date of Admission**	18-Jun-2022
Date of Discharge	21-Jun-2022		
MLC No			
Address	BOIWADA KARIMNAGAR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 1
Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		

SEPSIS WITH MODS

AKI

SHOCK

C/o fever, vomitings, loose stools since 1 day

K/c/o HTN, Dyslipidemia

AT ADMISSION:

PR: 110/min

BP: 50/30mmHg

RS: B/l crackles, decreased air

CVS: S1S2

RR: 24/min

SPO2: 95% 6L/min

P/A: Soft

A 81 years old female patient Mrs. A VAJARAMMA presented with the above-mentioned complaints, on initial examination patient had profound hypotension 1 L NS fluid challenge was given. Following which the BP improved to 80/60 mmHg then patient was started on ionotropic support. The patient was started on INJ. MEROPENEM and INJ. TEICOPLANIN, blood cultures and urine cultures were sent, reports are pending. The Sr. Procalcitonin was 81.6 pg per mL. Patient required oxygen via nasal prongs at 4 L/min now it has decreased to 2 L/min. The patient is clinically better since admission. The patient requires further hospitalisation but attenders are unwilling hence patient is being discharged against medical advice

ARH1.0001232111		**Name**	Mr. KOMARAIAH A
Patient Identifier	ARHIP56168	**Age**	64Yr 4Mth 11Days
Sex	Male	**Date of Admission**	14-Jun-2022
Date of Discharge			
MLC No			
Address	SURVERY NO 52, BACK SIDE OF LADDA RICE MILL, GADDERAGADI, MANCHERIAL,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 2
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch		

LEFT EPIDIDYMO ORCHITIS
SURGERY: CYSTOSCOPY DONE 20/06/2022

C/o pain, swelling in the left groin, scrotum since 5 days
Pain in the right groin scrotum since 3 days

ON ADMISSION

Patient c/c

PR-102/min

BP-100/60mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-96%

A 64 years old male patient KOMARAIAH presented to hospital with c/o pain, swelling in the left groin, scrotum since 5 days, pain in the right groin scrotum since 3 days. All necessary investigations were done and diagnosed as LEFT EPIDIDYMO ORCHITIS, SURGERY: CYSTOSCOPY DONE 20/06/2022. Post operative period was uneventful. Neuro physician consultation taken and advice followed. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB: URIMAX ONCE DAILY AT 8 PM FOR 7 DAYS.
6. CAP: LUMIA D3 60K ONCE IN A WEEK FOR 1 MONTH
7. TAB: SHELCAL-XT ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS TO UROLOGY OPD.

56236

ARH1.0001232301		**Name**	Mr. SURYA NARAYANA T		
	Patient Identifier	ARHIP56236		**Age**	75Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	19-Jun-2022
	Date of Discharge				
	MLC No				
	Address	12-678,Adilabad(Adilabad),Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

COMPLETE HEART BLOCK WITH CORONARY ARTERY DISEASE, ACUTE IWMI

NORMAL LV SYSTOLIC FUNCTION, EF 56%
TPI DONE ON 19/06/2022
CORONARY ANGIOGRAM DONE ON 19/06/2022 – CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 32 MM METAFOR DONE ON 19/06/2022
R/F: HTN

C/o chest pain since 1 day associated with sweating

AT ADMISSION:

Afebrile

PR: 92/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 75years old male patient Mr. SURYA NARAYANA came with c/o chest pain since 1 day associated with sweating. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK WITH CORONARY ARTERY DISEASE, ACUTE IWMI, NORMAL LV SYSTOLIC FUNCTION, EF 56%, TPI DONE ON 19/06/2022, CORONARY ANGIOGRAM DONE ON 19/06/2022 – CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 32 MM METAFOR DONE ON 20/06/2022 [LOT NO: MH42, S/N :CM32MH42043]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. LIPRIL 5 MG ONCE DAILY AT 8AM TO CONTINUE.

6)TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

7)SYP. POTKLOR 10 ML THRICE DAILY AT 8AM, 2PM, 8PM FOR 2 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

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ARH1.0001232393		**Name**	Mrs. VIJAYA LAXMI
Patient Identifier	ARHIP56264	**Age**	60Yr 0Mth 2Days
Sex	Female	**Date of Admission**	21-Jun-2022
Date of Discharge			
MLC No			
Address	Godavarikhani Peddapalli,Ramagundam,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU13
Primary Consultant	Dr. KRISHNA CHAITANYA M		

CORONARY ARTERY DISEASE , AWSTEMI

SEVERE LV DYSFUNCTION,

PULMONARY EDEMA

CARDIOGENIC SHOCK

KILLIP CLASS-IV

HEART FAILURE

FC-IV

SINUS RHYTHM

CORONARY ANGIOGRAM DONE ON 21/06/2022 – CAD-LM+TVD

PLAN CABG.

C/o sudden onset chest pain since 1 day

At Admission

Afebrile

PR: 96/min

BP: 100/50 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-100%

A 60 years old female patient Mrs. VIJAYA LAXMI came with c/o sudden onset chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , AWSTEMI, SEVERE LV DYSFUNCTION, PULMONARY EDEMA, CARDIOGENIC SHOCK, CORONARY ANGIOGRAM DONE ON 21/06/2022 – CAD-LM+TVD, CTVS consultation taken and adviced CABG surgery. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. ATORVA 40 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. LASIX 20 MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
3. TAB. ALDACTONE 25 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001232353		**Name**	Mr. SYED MOIN UDDIN
Patient Identifier	ARHIP56253	**Age**	51Yr 0Mth 3Days
Sex	Male	**Date of Admission**	20-Jun-2022
Date of Discharge			
MLC No			
Address	3-3-130, JAGITYAL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI

NORMAL LV SYSTOLIC FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 20/06/2022 – CAD-DVD (RCA, LCX)

PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR, LCX WITH 2.75 X 29 MM DONE ON 20/06/2022
R/F: HTN, T2DM

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 102/min

BP: 100/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft

A 51 years old male patient Mr. SYED MOIN UDDIN came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NORMAL LV SYSTOLIC FUNCTION, EF-60% ,CORONARY ANGIOGRAM DONE ON 20/06/2022 – CAD-DVD (RCA, LCX), PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR, LCX WITH 2.75 X 29 MM DONE ON 20/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. NOVASTAT 10MG ONCE DAILY AT 8AM TO CONTINUE.

4) TAB. BETALOC 150 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. GLYCOMET SR 850 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

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ARH1.0001232361		**Name**	Mr. MARRI SLEEVA REDDY		
	Patient Identifier	ARHIP56263		**Age**	71Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	21-Jun-2022
	Date of Discharge				
	MLC No				
	Address	8-7-179/1, KOTHIRAMPUR,,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU1 1
	Primary Consultant	Dr. KRISHNA CHAITANYA M			

CAG: MILD CORONARY ARTERY DISEASE

CALCIFIC

SEVERE AORTIC STENOSIS

MODERATE LV DYSFUNCTION

GLOBAL LV HYPOKINESIA

CONTRACTED HF

SINUS RHYTHM

Complaints of worsening dyspnea NYHA, FC-II to FC-IV over last couple of weeks

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 91/min

BP: 100/70mmHg

RS: B/l basal crepts+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft

Mr. MARRI SLEEVA REDDY 71 year old male patient presented with complaints of worsening dyspnea NYHA, FC-II to FC-IV over last couple of weeks. On evaluation, he was and heart failure and pulmonary edema with bilateral crepitations. With IV diuretics and heart failure medication, he improved symptomatically. Once stabilized, coronary angiogram was done. CAG showed mid LAD 50% stenosis (moderate CAD) . He required medical management only for coronary artery disease. With severe calcific aortic stenosis, with onset of dyspnoea and a heart failure, poor prognosis explained to family members. Explained the option of aortic valve replacement and TAVR. In view of LV dysfunction, AVR is relatively high risk for him. Options were discussed with family members. Patient is being discharged in hemodynamically stable with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. FRUSELAC DS 1 TAB AT 8AM AND ½ TAB AT 8 PM TO CONTINUE.
3. TAB. LASIX 40MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

PatientDetails

UHID	ARH1.0001232362	**Name**	Mr. VPJ VENKATESH
Patient Identifier	ARHIP56291	**Age**	52Yr 0Mth 2Days
Sex	Male	**Date of Admission**	23-Jun-2022
Date of Discharge			
MLC No			
Address	B9, CC TOWNSHIP,SCCL,,Mancherial,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME6
Primary Consultant	Dr. KRISHNA CHAITANYA		

MILD MID LAD

MYOCARDIAL BRIDGING

NO OBSTRUCTIVE CAD

Complaints of worsening dyspnea NYHA, FC-II to FC-IV over last couple of weeks

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

Mr. VPJ. VENKATESH 52 year old male patient presented with complaint of angina on evaluation, his TMT test was stage-II positive for inducible ischaemia. Hence, coronary angiogram done showed mid LAD, mild myocardial bridging. He was started on beta-blocker and advised medical management. He was asymptomatic and stable at the time of discharge.

DISCHARGE MEDICATION:

---

1. TAB. AZTOR 10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
3. CONTINUE DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001232292		**Name**	Mr. MURALI CHINTHA
Patient Identifier	ARHIP56230	**Age**	45Yr 0Mth 6Days
Sex	Male	**Date of Admission**	18-Jun-2022
Date of Discharge			
MLC No			
Address	H.NO:5-5-158,JAGITIAL,Other,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

SEVERE LV DYSFUNCTION, EF-25%

CORONARY ANGIOGRAM DONE ON 21/06/2022 – CAD-SVD (LAD, D1)

PTCA+DES TO LAD, D1 (TWO STENTS) LAD WITH 3.5 X 19 MM METAFOR, D1 WITH 2.5 X 24 MM METAFOR DONE ON 21/06/2022

C/o chest pain since 1 month,

H/o SOB since 1 day

AT ADMISSION:

Afebrile

PR: 125/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 88%

P/A: Soft

A 45 years old male patient Mr. MURALI CHINTHA came with c/o chest pain since 1 month, h/o SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SEVERE LV DYSFUNCTION, EF-25%, CORONARY ANGIOGRAM DONE ON 21/06/2022 – CAD-SVD (LAD, D1), PTCA+DES TO LAD, D1 (TWO STENTS) LAD WITH 3.5 X 19 MM METAFOR, D1 WITH 2.5 X 24 MM METAFOR DONE ON 21/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

3) TAB. CARDIVAS 6.25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. PRASUDOC 10 MG ONCE DAILY AT 2PM AFTER LUNCH TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

APH1.0001082707		**Name**	Mr. BARLA BEERAIAH		
	Patient Identifier	ARHIP56276		**Age**	62Yr 10Mth 1Days
	Sex	Male		**Date of Admission**	21-Jun-2022
	Date of Discharge				
	MLC No				
	Address	VILLAGE CHILLAPALLY MANDAL MANTHANI,Karimnagar,Andhra Pradesh		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 2
	Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal			

ACUTE FEBRILE ILLNESS WITH ACUTE CVA

C/o fever associated with giddiness and vomitings, generalized weakness

K/C/O HTN, DM

AT ADMISSION:

Afebrile

PR: 68/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. BARLA BEERAIAH came with c/o fever associated with giddiness and vomitings, generalized weakness. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS WITH ACUTE CVA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75 MG ONCE DAILY AT 8PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. STROCOT PLUS **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. SUPRA PLUS ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS

8) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232219		**Name**	Mr. SANTHOSH BHEEMA		
	Patient Identifier	ARHIP56202		**Age**	25Yr 0Mth 8Days
	Sex	Male		**Date of Admission**	16-Jun-2022
	Date of Discharge				
	MLC No				
	Address	MALLANNAPET, GOLLAPALLI,JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:119 B
	Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY			

DELIBERATE SELF HARM
PARAQUAT POISONING
HEPATITIS
MUCOSITIS

Came with history of consumption of unknown quantity of paraquat

AT ADMISSION:

Patient c/c

PR: 81/min

BP: 140/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 25 years old male patient Mr. SANTHOSH BHEEMA came with came with history of consumption of unknown quantity of paraquat . All necessary investigations were done and diagnosed as DELIBERATE SELF HARM, PARAQUAT POISONING, HEPATITIS, MUCOSITIS. Gastric lavage with 5 L of normal saline given. 250 gms of activated Charcoal. Haemoperfusion done 3 cycles, Patient stabilized. IV steroids and IV Cyclophosphomides were given. Patient showed some improvement. He is being discharged in a haemodynamically stable condition.

DISCHARGE MEDICATION:

---

1) SYP. SUCRAL 1 tsp **THRICE IN A DAY AT 8 AM 2 PM 8 PM** FOR 5 DAYS

2) SYP. MUCAINE GEL 10 ml **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

3) TAB. LONAZEP 0.5 MG ONCE DAILY AT 8PM FOR 5 DAYS

4) TAB. SERTA 25 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

5) TAB. WYSOLONE 10MG ONCE DAILY AT 2PM FOR 5 DAYS

6) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS

7) TAB. SHELCAL 1 GM ONCE DAILY AT 2PM FOR 5 DAYS

8) TAB. UBILIFE ONCE DAILY AT 2PM FOR 5 DAYS

9) TAB. HEPAMERZ SACHETS ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001232351		**Name**	Mrs. RADHA PASARAKONDA
Patient Identifier	ARHIP56249	**Age**	59Yr 5Mth 23Days
Sex	Female	**Date of Admission**	20-Jun-2022
Date of Discharge			
MLC No			
Address	16-2-31, SHIVAJINAGAR, GODAVARIKHANI PEDDAPALLY,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:106 A
Primary Consultant	DR. SRI KARAN UDDESH --		

RHEUMATOID ARTHRITIS FLARE,
CERVICAL RADICULOPATHY
TYPE II DIABETES MELLITUS

C/o Multiple joint pains

H/o Generalized weakness since 2 months
Known case of diabetic mellitus on treatment
Known case of rheumatoid arthritis not on treatment

AT ADMISSION:

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% on room air

P/A: Soft,

A 59 years old female patient Mrs. RADHA PASARAKONDA came with above mentioned complaints, patient presented with the above-mentioned complaints patient was diagnosed to RHEUMATOID ARTHRITIS FLARE, CERVICAL RADICULOPATHY, TYPE II DIABETES MELLITUS and was started on INJ. NUERIT PLUS, INJ. PAN, TAB WYSOLONE, TAB. PREGABID and other supportive

treatment. Neurosurgeon consultation taken and advice followed. The patient is symptomatically better and is being discharged with following advice.

DISCHARGE MEDICATION:

---

1. TAB. WYSOLONE 20 MG ONCE DAILY AT 2PM FOR 5 DAYS THEN
   TAB. WYSOLONE 10 MG ONCE DAILY AT 2PM FOR 5 DAYS THEN
   TAB. WYSOLONE 5 MG ONCE DAILY AT 2PM FOR 5 DAYS THEN STOP
2. TAB. METHOTREXATE 7.5 MG OD ON WEDNESDAY ONLY FOR 30 DAYS
3. TAB. FOLVITE 5 MG OD EXCEPT ON WEDNESDAY FOR 30 DAYS
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. VIDLA-M 50/500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 30 DAYS
6. TAB. GABAPIN-NT ONCE DAILY AT 8PM FOR 30 DAYS
7. TAB. NEURIT-CD3 ONCE DAILY AT 2PM FOR 30 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001231324		**Name**	Mr. JEEVAN REDDY K		
	Patient Identifier	ARHIP56277		**Age**	32Yr 0Mth 30Days
	Sex	Male		**Date of Admission**	21-Jun-2022
	Date of Discharge				
	MLC No				
	Address	DHARMARAM, PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:123 A
	Primary Consultant	Dr. GOUTHAM ROY (MS(General			

MULTIPLE LIPOMATOSIS

SURGERY : MULTIPLE EXCISION OF LIPOMAS DONE ON 23/06/2022

C/o multiple lipomas

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 32 yr old male patient Mr. JEEVAN REDDY K came with c/o multiple lipomas . All necessary investigations done and diagnosed as MULTIPLE LIPOMATOSIS, SURGERY : MULTIPLE EXCISION OF LIPOMAS DONE ON 23/06/2022. Findings: Multiple lipomas involving bilateral UL & LL with Abd. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG **TWICE IN A DAY AT 8 AM 8 PM** 5 DAYS.
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

REVIEW AFTER 10 DAYS IN GENERAL SURGERY OPD.

ARH1.0001232480		**Name**	Mr. CH VAIKUNTAM		
	Patient Identifier	ARHIP56301		**Age**	65Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	MANCHERIYAL,Adilabad(Adilabad),Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 5
	Primary Consultant	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY			

CORONARY ARTERY DISEASE-CSA

TMT STAGE-II POSITIVE

NO HF, FC-II AOE, SR

CAG: ECTATIC CORONARIES WITH MINOR CAD- SLOW FLOW

PLAN-MEDICAL MANAGEMENT

C/o angina on exertion since 4 months a/w chest pain

K/c/o T2DM

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

Mr. CH VAIKUNTAM 65 years old male patient presented with c/o angina on exertion since past 4 months, worsening from FC-II-III in last 2 months. TMT done was stage-II positive for inducible ischaemia. Coronary angiogram done showed Ectatic coronaries with slow flow and minor CAD. His medications were optimised and being discharged with the following advice

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN-AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.

2. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM AND 8 PM** TO CONTINUE.

3. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM AND 2 PM** TO CONTINUE.

4. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM, 2PM AND 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001080684		**Name**	Mr. VENKATARAM REDDY ADABOINA		
	Patient Identifier	ARHIP56283		**Age**	58Yr 1Mth 18Days
	Sex	Male		**Date of Admission**	22-Jun-2022
	Date of Discharge				
	MLC No				
	Address	HUSNABAD,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
	Primary Consultant	Dr. KRISHNA CHAITANYA M -- CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CAG+PTCA TO LAD 1 STENT DONE ON 22/06/2022

C/o chest pain, shortness of breath since 1 day

AT ADMISSION:

Afebrile

PR: 123/min

BP: 150/110 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 58 years old male patient Mr. VENKATARAM REDDY ADABOINA came with history of chest pain was evaluated and diagnosed to have AWSTEMI, primary PTCA to LAD with drug eluting stent with 4 x 24 mm stent. Good result TIMI-III flow. He was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

---

1) TAB. AXCER 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

2) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.

5) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

6) TAB. NITROCONTIN 2.6 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

7) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.

8) TAB. FRUSELAC-DS ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD [30/06/2022] WITH CBC, RP2, FLP REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001219067		**Name**	Mrs. SHAIK AMEENA BEGAM
Patient Identifier	ARHIP56233	**Age**	47Yr 0Mth 17Days
Sex	Female	**Date of Admission**	19-Jun-2022
Date of Discharge			
MLC No			
Address	4-3-6, METPALLY JAGTIAL 6300746239,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 1
Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY) (NIMS),RENAL TRANSPLANT PHYSICIAN)--NEPHROLOGY		

S

CHRONIC KIDNEY DISEASE

C/o Shortness of breath, b/l pedal edema

AT ADMISSION:

PR: 124/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

A 47 years old female patient Mrs. SHAIK AMEENA BEGAM came with c/o shortness of breath, b/l pedal edema. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE. Managed conservatively. 4 sessions of hemodialysis were done. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. SOBINIX DS ONCE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. CLOCEF-CV **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
3. TAB. KETOCHECK THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
4. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001231339		**Name**	Mr. T GOPI		
	Patient Identifier	ARHIP56320		**Age**	32Yr 0Mth 30Days
	Sex	Male		**Date of Admission**	24-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Metpalli,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 4
	Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology			

LEFT DJ STENT
SURGERY: LEFT DJ STENT REMOVAL DONE ON 24.06.2022

Patient came for left DJ stent removal

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 32 yrs old male patient Mr. GOPI came for left DJ stent removal. SURGERY: LEFT DJ STENT REMOVAL DONE ON 24.06.2022. Post operative period was uneventful. Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DROLGON TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 5DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD

56226

.0001232074		**Name**	Mr. DAYYALA KANKAIAH		
	Patient Identifier	ARHIP56226		**Age**	60Yr 10Mth 11Days
	Sex	Male		**Date of Admission**	18-Jun-2022
	Date of Discharge				
	MLC No				
	Address	2-10-596, JYOTHI NAGAR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 23
	Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY			

PROSTATOMEGALY
SURGERY: TURP DONE ON 20/06/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 60 yrs old male patient Mr. DAYYALA KANKAIAH came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as PROSTATOMEGALY , SURGERY: TURP DONE ON 20/06/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD

56223

ARH1.0001232113		**Name**	Mrs. SRAVANTHI K		
	Patient Identifier	ARHIP56223		**Age**	32Yr 0Mth 10Days
	Sex	Female		**Date of Admission**	18-Jun-2022
	Date of Discharge				
	MLC No				
	Address	PANNUR,Ramagundam,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 9
	Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch			

RIGHT RENAL CALCULUS
RIGHT PCNL+DJ STENTING DONE ON 20.06.2022

C/o Right loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 32 yrs old female patient Mrs. SRAVANTHI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, SURGERY: RIGHT PCNL+DJ STENTING DONE ON 20.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

---

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232450	**Name**	Mrs. B SRILATHA		
Patient Identifier	ARHIP56318		**Age**	48Yr 0Mth 2Days
Sex	Female		**Date of Admission**	24-Jun-2022
Date of Discharge				
MLC No				
Address	STHAMMAPLLI BOINPALLY,Sircilla,Telangana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 6
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--		**Consultants**	

GENERAL SURGERY

Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56318	ARH1.000123245

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
STAPLER HAEMORRHOIDECTOMY				

GRADE-IV INTERNAL HEMORRHOIDS
SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 24/06/2022

C/o pain and bleeding per rectum since 10 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-130/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 48 yrs old female patient SRILATHA came with c/o pain and bleeding per rectum since 10 days. All necessary investigations done and diagnosed as GRADE-IV INTERNAL HEMORRHOIDS, SURGERY: STAPLER HEMORRHOIDECTOMY DONE ON 24/06/2022. Findings: Multiple internal hemorrhoids noted @ 3'O & 7'O clock in position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
4. XYLOCAINE JELLY EVERY 4th hrly
5. SITZ BATH
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001220341		**Name**	Mr. JAFFAR KHAN MD		
	Patient Identifier	ARHIP56240		**Age**	65Yr 9Mth 30Days
	Sex	Male		**Date of Admission**	20-Jun-2022
	Date of Discharge				
	MLC No				
	Address	LAXMI NAGAR, PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, AWMI [RECURRENT INFARCTION]

DRUG NON COMPLIANCE

K/C/O CAD- ACUTE AWMI

CORONARY ANGIOGRAM (30/08/2021) -SHOWING SLOW FLOW IN ALL CORONARIES, LAD PROXIMAL MILD STENOSIS WITH A SMALL CORONARY ANEURYSM

BPH (TO RULE OUT PROSTATE CA)

UTI (Fever with Thrombocytopenia)

C/o retrosternal chest pain radiating to back associated with sweating since 1 day
History of burning micturition since 15 days

Known case of hypertension,
Right renal calculi operated at 26 years back

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old male patient JAFFAR KHAN came with c/o retrosternal chest pain radiating to back associated with sweating since 1 day, history of burning micturition since 15 days. All necessary investigations were done and diagnosed as
I) CORONARY ARTERY DISEASE, AWMI [RECURRENT INFARCTION], DRUG NON COMPLIANCE, K/C/O CAD- ACUTE AWMI, CORONARY ANGIOGRAM (30/08/2021) -SHOWING SLOW FLOW IN ALL CORONARIES, LAD PROXIMAL MILD STENOSIS WITH A SMALL CORONARY ANEURYSM + BPH (TO RULE OUT PROSTATE CA) + A UTI + THROMBOCYTOPENIA. Patient was deferred coronary angiogram due to reasons of
1. Thrombocytopenia
2. UTI with fever and chills
3. Raised Sr. Creatinine
4. Resolution of ECG changes
5. subsiding of chest pain and breathlessness after giving antiplatelets and anticoagulants

II) BPH and UTI for which nephrology and Urology consultation was done and treated accordingly.

III) Thrombocytopenia for which General Physician Consultation was done and treated accordingly.

Patient is being planned discharged medical management and foley's catheter in situ in a haemodynamically stable condition.

Review to Urology OPD, Nephrology OPD and Cardiac OPD with RP-II and CBC reports after 1 week

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. FAROBACT 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. SOBINEX DS 500MG ONCE DAILY AT 8AM TO CONTINUE.

6. TAB. RENOSAVE 40MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. URIMAX-D ONCE DAILY AT 8PM TO CONTINUE.
9. SYP. ALKAPAN 1tsp **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.
10. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 7 DAYS
11. TAB. DOLO 650 MG **TWICE IN A DAY AT 8 AM, 8 PM** FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232258		**Name**	Mr. NAGARAJU REDDY
Patient Identifier	ARHIP56219	**Age**	0Yr 0Mth 8Days
Sex	Male	**Date of Admission**	18-Jun-2022
Date of Discharge			
MLC No			
Address	KRISHANA COLONY RK 6,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:105 B
Primary Consultant	DR. SUBRAT KUMAR SOREN		

1.CEREBRAL VENOUS THROMBOSIS
[ANTERIOR TWO THIRD SUPERIOR SAGITTAL SINUS THROMBOSIS]
2.HAEMORRHAGIC INFARCT
3.SEIZURE DISORDER

Complaint of neck pain, giddiness, 1 episode of seizure (GTCS)
History of retrosternal chest pain
History of seizures in childhood (5 years of age)
History of chronic alcoholic
Known case of hypertension

AT ADMISSION:

Patient c/c/c

PR: 69/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 29 yr old male patient NAGARAJU REDDY came to hospital with complaint of neck pain, giddiness, 1 episode of seizure (GTCS). All necessary investigations done and diagnosed as 1.CEREBRAL VENOUS THROMBOSIS [ANTERIOR TWO THIRD SUPERIOR SAGITTAL SINUS THROMBOSIS], 2.HAEMORRHAGIC INFARCT, 3.SEIZURE DISORDER. Conservative medical management given. Patient is being discharged in a hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ACITROM 2 MG ONCE DAILY AT 6 PM TO CONTINUE
2. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
3. TAB. CLOBAZAM 10 MG ONCE DAILY AT 8 PM TO CONTINUE
4. TAB. TELMA-H ONCE DAILY AT 8 AM TO CONTINUE
5. TAB. LIBRIUM 20 MG ONCE DAILY AT 8 PM TO CONTINUE
6. TAB: PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
7. TAB: AUGMENTIN DUO 625 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
8. TAB. DOLO 650 TWICE DAILY AT 8AM, 8PM FOR 5DAYS.
9. TAB. BENFOMATE PLUS ONC**E IN A DAY AT 2 PM** FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD WITH PT, APTT+INR.

ARH1.0001231870

Name	Mrs. AMULA KASHAVVA		
Patient Identifier	ARHIP56153	**Age**	6
Sex	Female	**Date of Admission**	1
Date of Discharge			
MLC No			
Address	MITTAPALLI SIDDIPET MEDAK,Siddipet,Telangana	**Ward/Bed No**	F
Primary Consultant	Dr SOMASHEKAR K(MS,M		

CRHD WITH SEVERE MS + MODERATE AS

SURGERY: DVR, MVR WITH TTKC NO. 27 MM, AVR WITH TTKC NO. 17 MM MECHANICAL VALVE DONE ON 20/06/2022

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old female patient Mrs. AMULA KASHAVVA came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CRHD WITH SEVERE MS + MODERATE AS, SURGERY: DVR, MVR WITH TTKC NO. 27 MM, AVR WITH TTKC NO. 17 MM MECHANICAL VALVE DONE ON 20/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST DVR 2D ECHO REPORTS SHOWED POST DVR STATUS , PROSTHETIC VALVE INSITU, NO VALVULAR/ PARAVALVULAR LEAK, NORMAL LV FUNCTION. NO CLOT/PE/VEG, [EF-50%]

BMI is 21 kg/m2.

Sr. Creatinine report done on 21.06.2022 0.9 mg/dl

DISCHARGE MEDICATION:

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1) TAB. ACITROM 1 MG & 2MG ALTERNATE DAY AT 7PM TO CONTINUE.

2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

4) TAB. ND VIT ONCE DAILY AT 2 PM TO CONTINUE

5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

6) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

8) SYP. CREMAFFIN 2tsp THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT-INR REPORTS

ARH1.0001232491		**Name**	Mrs. DEVENDRA A		
	Patient Identifier	ARHIP56316		**Age**	50Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	24-Jun-2022
	Date of Discharge	25-Jun-2022			
	MLC No				
	Address	ALUGUNUR,Karimnagar,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 7
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR(MD,DM(Neurology),Consultant Neuro Physician)--NEUROLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
BENZODIAZEPINE OVERDOSE	

Patient brought to Emergency Room in unconscious state

Known case of hypertension on irregular medication

AT ADMISSION:

Afebrile

PR: 96/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 50 years old female patient Mrs. DEVENDRA came with patient brought to Emergency Room in unconscious state. Known case of hypertension on irregular medication. All necessary investigations were done and diagnosed as BENZODIAZEPINE OVERDOSE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. SERTA 25 MG ONCE DAILY AT 2PM FOR 5 DAYS
2. TAB. LONAZEP 0.5 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
3. TAB. FLEXURA-D TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
4. TAB. PANTOCID DSR ONCE DAILY AT 7AM (BBF) FOR 5 DAYS.

REVIEW AFTER 5 DAYS IN DR. SANJAY KUMAR SIR OPD

ARH1.0001231273		**Name**	Mrs. U KANAKAMMA		
	Patient Identifier	ARHIP56289		**Age**	73Yr 1Mth 1Days
	Sex	Female		**Date of Admission**	22-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Delux Room, Bed no:104
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE			

GLIOBLASTOMA MULTIFORME

Patient has decreased response since 2 days
shortness of breath grade -III since 2-3 days

Known case of glioblastoma multiforme

AT ADMISSION:

Afebrile

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% on room air

P/A: Soft,

A 73 years old female patient KANAKAMMA came with above mentioned complaints. Patient diagnosed as GLIOBLASTOMA MULTIFORME. Patient admitted only for palliative treatment with end of Life Care. All the aspects have been explained to the relatives. Her son Mr. Sudarshan signed a paper to that effect. Now they want the patient to be discharged against medical advice . GCS 6/15.

ARH1.0001232400		**Name**	Mr. V VINAY KUMAR
Patient Identifier	ARHIP56271	**Age**	31Yr 0Mth 4Days
Sex	Male	**Date of Admission**	21-Jun-2022
Date of Discharge			
MLC No			
Address	kamanpur,peddapalli,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:122 B
Primary Consultant	Dr Chandra Shekar Sathineni		

ACUTE FEBRILE ILLNESS
ACUTE VIRAL HEPATITIS (HEPATITIS - A)

Complaint of fever with chills since 7 days
History of vomitings, blood in urine
Yellowish discolouration of eye, generalised weakness

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/60 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 31 years old male patient Mr. V VINAY KUMAR came with c/o fever with chills since 7 days, history of vomitings, blood in urine, Yellowish discolouration of eye, generalised weakness. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS, ACUTE VIRAL HEPATITIS (HEPATITIS - A). Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. URSOCOL 300 MG TWICE DAILY AT 8AM AND 8PM FOR 30 DAYS

2) TAB. MEBGRAM 200 MG TWICE DAILY AT 8AM AND 8PM FOR 30 DAYS

3) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 30 DAYS.

4) SYP. APTIVATE 5 ML TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232442		**Name**	Mrs. BALAMANI CH		
	Patient Identifier	ARHIP56296		**Age**	48Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	8 IN CLINE COLONY, RAMAGUNDAM,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:108 A
	Primary Consultant	Dr. SURESH GOUD S(MS,			

LEFT PYELONEPHRITIS
SURGERY: LEFT DJ STENTING DONE ON 23.06.2022

C/o no urine output since 1 day

Left flank pain since 1 day

Known case of hypertension since 2 years
History of right nephrectomy in 2004
S/P right thalamic haematoma

ON ADMISSION

Patient c/c

Afebrile

PR-81/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 48 years old female patient Mrs. BALAMANI presented to hospital with c/o no urine output since 1 day, left flank pain since 1 day. All necessary investigations were done and diagnosed as LEFT PYELONEPHRITIS, SURGERY: LEFT DJ STENTING DONE ON 23.06.2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DROLGON TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB. VELTAM 0.2 MG ONCE DAILY AT 8PM FOR 14 DAYS.
6. SYP. ALKAPAN 15 ml **THRICE IN A DAY AT 8 AM, 2PM & 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO UROLOGY OPD.

REVIEW AFTER 3 WEEKS FOR DJ STENT REMOVAL.

ARH1.0001231781		**Name**	Mrs. PRAMEELA AREPALLI		
	Patient Identifier	ARHIP56257		**Age**	41Yr 0Mth 19Days
	Sex	Female		**Date of Admission**	20-Jun-2022
	Date of Discharge				
	MLC No				
	Address	8-9, VEDIRA,KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 3
	Primary Consultant	Dr. SURESH GOUD S(MS			

RIGHT RENAL CALCULUS
SURGERY : RIGHT PCNL + DJ STENTING DONE ON 21.06.2022

C/o Right loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 41 yrs old female patient PRAMEELA AREPALLI came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, SURGERY : RIGHT PCNL + DJ STENTING DONE ON 21.06.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

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1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 11DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232298		**Name**	Mrs. GOSKULA ILAVVA		
	Patient Identifier	ARHIP56232		**Age**	76Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	19-Jun-2022
	Date of Discharge				
	MLC No				
	Address	CHERLABUTHKUR,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 2
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR			

ACUTE POSTERIOR CIRCULATION STROKE

Complaints of slurring of speech

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 76/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft,

A 76 years old female patient Mrs. GOSKULA ILAVVA came with complaints of slurring of speech. All necessary investigations done and diagnosed as ACUTE POSTERIOR CIRCULATION STROKE. Managed conservatively . Patient improved symptomatically, hence now patient is being discharged in a hemodynamically stable condition with all the required medications and advice.

DISCHARGE MEDICATION :

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1) TAB. PREVA-AS 75 MG ONCE DAILY AT 2PM FOR 10 DAYS

2) TAB. COLTRO 10 MG ONCE DAILY AT 8PM FOR 10 DAYS

3) TAB. DUZELLA 20 MG ONCE DAILY AT 2PM FOR 10 DAYS

4) TAB. SPINFREE ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 11 DAYS IN DR. SANJAY KUMAR SIR OPD

ARH1.0001232352		**Name**	Mrs. VENNAM MALLAVVA
Patient Identifier	ARHIP56252	**Age**	66Yr 5Mth 5Days
Sex	Female	**Date of Admission**	20-Jun-2022
Date of Discharge			
MLC No			
Address	9-5-193, RAMNAGAR,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 11
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

ACUTE INFARCTS IN POSTERIOR CIRCULATION

Complaint of giddiness and vomitings multiple episodes since 2 days

Known case of hypertension on regular medication

AT ADMISSION:

Afebrile

PR: 75/min

BP: 130/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft,

A 66 years old female patient Mrs. VENNAM MALLAVVA came with complaints of giddiness and vomitings multiple episodes since 2 days. All necessary investigations done and diagnosed as ACUTE INFARCTS IN POSTERIOR CIRCULATION. Managed conservatively . Patient improved symptomatically, hence now patient is being discharged in a hemodynamically stable condition with all the required medications and advice.

DISCHARGE MEDICATION :

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1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 10 DAYS

2) TAB. ATORVA 40 MG ONCE DAILY AT 2PM FOR 10 DAYS

3) TAB. SUPRADYN ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI SIR OPD

ARH1.0001232405		**Name**	Mr. S D MOULANA		
	Patient Identifier	ARHIP56278		**Age**	71Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	21-Jun-2022
	Date of Discharge				
	MLC No				
	Address	NEW MOGALIPALEM,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 21
	Primary Consultant	Dr. KRISHNA CHAITANYA			

CAD, IWSTEMI
CAG: RCA TOTAL THROMBOTIC OCCLUSION
LAD MID 60% STENOSIS
FAIR LV FUNCTION, LVEF 50%
SINUS RHYTHM

Complaint of chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Mr. MOULANA , 71-year-old gentleman came with complaint of chest pain since 1 day. On evaluation showed STEMI. He was taken up for primary angioplasty, PTCA to RCA done and LAD vessel had borderline 60% stenosis. He was stabilised and medication was optimised. He was symptomatically better and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 1 WEEK TO CARDIAC OPD WITH CBC, RP-2 TO REPORTS

ARH1.0001098189		**Name**	Mrs. MANCHALA VASANTHA		
	Patient Identifier	ARHIP56259		**Age**	40Yr 4Mth 29Days
	Sex	Female		**Date of Admission**	21-Jun-2022
	Date of Discharge				
	MLC No				
	Address	MODELA,Adilabad(Adilabad),Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 22
	Primary Consultant	Dr. KRISHNA CHAITANYA			

CAD, OLD AWMI, S/P PTCA TO LAD
NOW, UNSTABLE ANGINA
NOW H F,
LVEF 35%-40%,
SINUS RHYTHM
CAG: RCA MID 80% STENOSIS
PTCA TO RCA (3.5 X 16 MM METAPHOR) DONE ON 22/06/2022

Complaint of chest discomfort since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Mrs. MANCHALA VASANTHA 40-year-old female presented with chest discomfort, unstable angina. Evaluated and CAG done showed mid RCA 80% stenosis. Hence PTCA to RCA with 3.5 x 15 mm Metahor stent. TIMI, III flow. Good result. Her medications were optimized. She was stable and symptomatically better at the time of discharge.

DISCHARGE MEDICATION:

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1. TAB. CLOPIDOGREL 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PANTODAC 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
5. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. IVABRADINE 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. CONTINUE DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 1 WEEK TO CARDIAC OPD WITH CBC, RP-2 TO REPORTS

ARH1.0001132332		**Name**	Mrs. A RATNAMMA		
	Patient Identifier	ARHIP56285		**Age**	73Yr 0Mth 19Days
	Sex	Female		**Date of Admission**	22-Jun-2022
	Date of Discharge				

MLC No			
Address	SIRCILLA,Karimnagar,Telangana	**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 1
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56285	ARH1.000113233

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
OPEN VENTRAL HERNIA REPAIR WITH MESH REPAIR ONLEY				

S

VENTRAL HERNIA INVOLVING RIGHT ABDOMINAL WALL

SURGERY: OPEN VENTRAL HERNIA REPAIR (ONLY MESH REPAIR) DONE ON 24/06/22

C/o swelling over right abdomen region since few days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-81/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 73yr old female patient Mrs. A. RATNAMMA came with c/o swelling over right abdomen region since few days. All necessary investigations done and diagnosed as VENTRAL HERNIA INVOLVING RIGHT ABDOMINAL WALL, SURGERY: OPEN VENTRAL HERNIA REPAIR (ONLY MESH REPAIR) DONE ON 24/06/22. Findings: Defect involving right lower abdomen measuring 3 x 2 cm with omentum as its contents. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: ROTAVAULT THRICE DAILY AT 8AM, 2PM & 8PM FOR 7 DAYS
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL SURGERY OPD.

56270

Chest pain associated with vomiting Since 1 day

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 90/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

Mr. Mr. MOHAMMED IBRAHIM 43-year-old male presented with chest pain associated with vomiting since 1 day.
CAG was done -Normal coronaries. His medication optimised . He was asymptomatic and haemodynamically stable at the time of discharge

DISCHARGE MEDICATION:

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1. TAB. ATORVA 10MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
3. TAB. ANKIT 0.2 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 1 WEEK TO CARDIAC OPD

ARH1.0001232391		**Name**	Mrs. KALAVATHI BANDARI		
	Patient Identifier	ARHIP56266		**Age**	67Yr 5Mth 8Days
	Sex	Female		**Date of Admission**	21-Jun-2022
	Date of Discharge				
	MLC No				
	Address	6-8-82, SUBHASH NAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 9
	Primary Consultant	Dr. RAMCHANDER TORREM			

CHRONIC KIDNEY DISEASE, STAGE-V
HYPERTENSION
BRONCHIAL ASTHMA

C/o shortness of breath, decreased urine output and bilateral pedal oedema
Known case of hypertension, bronchial asthma

AT ADMISSION:

Afebrile

PR: 75/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 67 years old female patient Mrs. KALAVATHI BANDARI came with c/o shortness of breath, decreased urine output and bilateral pedal oedema, Known case of hypertension, bronchial asthma. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, STAGE-V, HYPERTENSION, BRONCHIAL ASTHMA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. FAROALFA 200MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. MOUNTAIR-AB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. FAROALFA 200MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MUCINAC THRICE IN A DAY AT 8 AM 2 PM 8 PM TO CONTINUE.
6. TAB. MONTAIR-AB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. SYP. ASCORYL-LS 5 ml THRICE IN A DAY AT 8 AM 2 PM 8 PM
8. NEB WITH DUOLIN, BUDERCORT **TWICE IN A DAY AT 8 AM 8 PM**
9. TAB. DYTOR 20MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. NICARDIA R 20MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO NEPHROLOGY OPD

ARH1.0001232565		**Name**	Mrs. D KALAVATHI		
	Patient Identifier	ARHIP56336		**Age**	62Yr 0Mth 4Days
	Sex	Female		**Date of Admission**	25-Jun-2022
	Date of Discharge				
	MLC No				
	Address	BELLAMPALLI,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 7
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR(MD,DM(Neurology),Consultant Neuro Physician)--NEUROLOGY			

CVA-ACUTE LEFT MCA INFARCT
THROMBOLISATION WITH TENECTASE ON 25/06/22

C/o right upper limb and lower limb weakness. H/o slurring of speech

ON ADMISSION

Pt c/c

Afebrile

PR-80/min

BP-130/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 62 years old female patient Mrs. KALAVATHI presented to hospital with c/o right upper limb and lower limb weakness. H/o slurring of speech. All necessary investigations were done and diagnosed as CVA-ACUTE LEFT MCA INFARCT, THROMBOLISATION WITH TENECTASE ON 25/06/22. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.

2) TAB. AZTOR 40MG 1TAB AT 9PM TO CONTINUE.

3) TAB. TELMA 40MG 1TAB AT 8AM TO CONTINUE.

4) TAB. ZORYL-M2 1TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 10 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD WITH FBS, PLBS REPORTS.

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ARH1.0001232476	**Name**	Mr. MUBEEN MOHAMMAD			
	Patient Identifier	ARHIP56303		**Age**	50Yr 4Mth 6Days
	Sex	Male		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	5-3-18, HAZARI STREET,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 18
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR			

CVA-ACUTE RIGHT MCA INFARCT

C/o sudden onset weakness of left upper limb and lower limb.

Known case of hypertension, diabetic mellitus, old CVA

ON ADMISSION

Pt c/c/c

Afebrile

PR-96/min

BP-140/90mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 50 years old male patient Mr. MUBEEN MOHAMMAD presented to hospital with c/o sudden onset weakness of left upper limb and lower limb . All necessary investigations were done and diagnosed as CVA-ACUTE RIGHT MCA INFARCT. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.

2) TAB. ATORVA 40MG 1TAB AT 9PM TO CONTINUE.

3) TAB. TELMA-H 1TAB AT 2PM TO CONTINUE.

4) TAB. GABAPIN NT 400/10 MG 1TAB AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD.

ARH1.0001232474	**Name**	Mr. THIRUPATHI PAIDI			
	Patient Identifier	ARHIP56299		**Age**	74Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Other,Other		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 15
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR(			

CVA-ACUTE RIGHT MCA INFARCT

C/o sudden onset weakness of left upper limb and lower limb.

Known case of hypertension, diabetic mellitus,

ON ADMISSION

Pt c/c/c

Afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 74 years old male patient Mr. THIRUPATHI PAIDI presented to hospital with c/o sudden onset weakness of left upper limb and lower limb . All necessary investigations were done and diagnosed as CVA-ACUTE RIGHT MCA INFARCT. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.

2) TAB. ATORVA 40MG 1TAB AT 9PM TO CONTINUE.

3) TAB. TELMIKIND 1TAB AT 2PM TO CONTINUE.

4) TAB. GLYCOMET 500 MG 1TAB AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD.

ARH1.0001232472		**Name**	Mr. MARUTHA RAJAMOULI
Patient Identifier	ARHIP56323	**Age**	57Yr 0Mth 6Days
Sex	Male	**Date of Admission**	24-Jun-2022
Date of Discharge			
MLC No			
Address	LUXETTIPET ,Telangana	**Ward/Bed No**	Second Floor, Semi Private , Bed no:123 C
Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE	**Consultants**	
Surgeons			

UNCONTROLLED DIABETES MELLITUS

C/o fever associated with Submandibular swelling

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 57 years old male patient Mr. MARUTHA RAJAMOULI came with c/o fever associated with Submandibular swelling. All necessary investigations were done and diagnosed as UNCONTROLLED DIABETES MELLITUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. ZERODOL- P TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. DOXT 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. ECOSPRIN 150/20 MG ONCE DAILY AT 2PM TO CONTINUE

4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBD FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232626		**Name**	Mrs. P LEELA		
	Patient Identifier	ARHIP56364		**Age**	56Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	27-Jun-2022
	Date of Discharge				
	MLC No				
	Address	MUDHIMANIKYAM,CHIGURUMAMIDI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:101 A
	Primary Consultant	DR. SRI KARAN UDDESH --			

DRUG OVERDOSE

Alleged history of consumption of Methylcobalamin and some other tablets on 26/06/2022

AT ADMISSION:

PR: 91/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 56 years old female patient Mrs. P LEELA came with above mentioned complaints. Patient diagnosed as DRUG OVERDOSE . Treated with Inj Pan, Emset and IV fluids. Psychiatrist consultation taken and advice followed.

Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. MIRTAZ 7.5 MG ONCE **IN A DAY AT 8 PM** FOR 7 DAYS
2. TAB. LONAZEP 0.5 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232576		**Name**	Mr. M SATHAIAH		
	Patient Identifier	ARHIP56339		**Age**	70Yr 0Mth 4Days
	Sex	Male		**Date of Admission**	25-Jun-2022
	Date of Discharge				
	MLC No				
	Address	MANKAMMA THOTA,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:103 A
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, STABLE ANGINA, TMT POSITIVE

NORMAL LV FUNCTION, EF-60%

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 25/06/2022 – CAD-2VD (LAD, RCA)

PTCA+DES TO D1 WITH 2.25 X 28 MM XIENCE XPEDITION DONE ON 25/06/2022
MEDICAL MANAGEMENT FOR PDA (THIN VESSEL)

C/o Retrosternal chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 70 years old male patient Mr. SATHAIAH came with c/o retrosternal chest pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, STABLE ANGINA, TMT POSITIVE, NORMAL LV FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 25/06/2022 – CAD-2VD (LAD, RCA), PTCA+DES TO D1 WITH 2.25 X 28 MM XIENCE XPEDITION DONE ON 25/06/2022, MEDICAL MANAGEMENT FOR PDA (THIN VESSEL). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. OMLEZEST 20 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. AMARYL MV2 ONCE DAILY AT 8AM TO CONTINUE.

7) TAB. ELTROXIN 100 MCG ONCE DAILY AT 7AM BBF TO CONTINUE.

8) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001214254		**Name**	Mr. ABDUL QAYYUM		
	Patient Identifier	ARHIP56355		**Age**	53Yr 0Mth 14Days
	Sex	Male		**Date of Admission**	26-Jun-2022
	Date of Discharge				
	MLC No				
	Address	manakondur,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:116 A
	Primary Consultant	Dr. RAMCHANDER TORREM			

ACUTE ON CHRONIC KIDNEY DISEASE
PULMONARY OEDEMA
HYPONATRAEMIA
CAD, DIABETIC MELLITUS, HYPERTENSION

C/o fever, vomiting, loose motions and severe shortness of breath grade- III and generalised weakness

Known case of hypertension, diabetes mellitus and chronic kidney disease

S/P Bladder neck incision 14/06/22

AT ADMISSION:

PR: 108/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% with 2Ltr O2

P/A: Soft

A 53 years old male patient Mr. ABDUL QAYYUM came with c/o fever, vomiting, loose motions and severe shortness of breath grade- III and generalised weakness. All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE, PULMONARY OEDEMA , HYPONATRAEMIA, CAD, DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Urologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. GLEVO 500 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. DYTOR 20MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. METOZ 10 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. CUDCE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. ROSA GOLD ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
8. TAB. GEROZ-LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 10 DAYS
9. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.
10. TAB. URIMAX 0.4 MG ONCE DAILY AT 8PM TO CONTINUE.
11. SALTED BUTTER MILK 200 ml QID FOR 10 DAYS

REVIEW AFTER 7 DAYS TO NEPHROLOGY OPD

ARH1.0001229381	**Name**	Mr. K MANOHAR			
	Patient Identifier	ARHIP56391	**Age**	62Yr 3Mth 1Days	
	Sex	Male	**Date of Admission**	28-Jun-2022	
	Date of Discharge				
	MLC No				
	Address	THANGALLAPALLY,Karimnagar,Telangana	**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 10	

Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesth

FISSURE IN ANO WITH GRADE –III INTERNAL HAEMORRHOIDS
SURGERY: LATERAL ANAL SPHINCTEROTOMY+,HEMORRHOIDECTOMY DONE ON 28/06/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 62 yrs old male patient Mr. MANOHAR came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as FISSURE IN ANO WITH GRADE –III INTERNAL HAEMORRHOIDS, SURGERY: LATERAL ANAL SPHINCTEROTOMY+,HEMORRHOIDECTOMY DONE ON 28/06/2022. Findings: Grade-III internal hemorrhoids noted in the anal canal @ 3'O clock in position, posterior fissure in ano. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. GLUTAVAULT –V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4th hrly

6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. SITZ BAH THRICE DAILY

Review after 10 days in General Surgery OPD.

ARH1.0001232540		**Name**	Mr. CHENDRAMOULI BETHI		
	Patient Identifier	ARHIP56328		**Age**	70Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	24-Jun-2022
	Date of Discharge				
	MLC No				
	Address	h-no:7-5-251,gm colony godavarikhani,peddapalli,Other,Telangana		**Ward/Bed No**	Second Floor, Semi Private, Bed no:111 B
	Primary Consultant	DR. SRI KARAN UDDESH -			

HFREF/AOCKD

ATRIAL FLUTTER

C/o right sided weakness since 4 days
Shortness of breath grade-III

Known case of hypertension, diabetic mellitus

AT ADMISSION:

PR: 90/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 70 years old male patient Mr. CHENDRAMOULI came with above mentioned complaints. Patient diagnosed as HFREF/AOCKD, ATRIAL FLUTTER. Treated with Inj Lasix, Heparin, Pan and other supportive medications. Nephrologist consultation taken and advice followed. Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. NODOSIS 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
2. TAB. SHELCAL-D ONCE **IN A DAY AT 2 PM** FOR 7 DAYS
3. TAB. SEVELAMER 800 MG THRICE **IN A DAY AT 8AM 2 PM** 8PM FOR 7 DAYS
4. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
5. TAB. MET-XL 50 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
6. TAB. WARFARIN 2 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
7. TAB. LASIX 20 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232595		**Name**	Mr. RAVINDER P		
	Patient Identifier	ARHIP56351		**Age**	53Yr 0Mth 3Days
	Sex	Male		**Date of Admission**	26-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KOURTALA,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU11
	Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,D			

CORONARY ARTERY DISEASE, ACUTE AWMI, SR

MILD LV DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 26/06/2022 – CAD-DVD (LAD, LCX)

PTCA+DES TO LAD, LCX [LAD WITH 2.75 X 40 MM 3V ASTRA, LCX WITH 2.5 X 36 MM] DONE ON 26/06/2022

C/o chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 53years old male patient Mr. RAVINDER came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SR, MILD LV DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 26/06/2022 – CAD-DVD (LAD, LCX), PTCA+DES TO LAD, LCX [LAD WITH 2.75 X 40 MM 3V ASTRA, LCX WITH 2.5 X 36 MM] DONE ON 26/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

3) TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

4) TAB. ATORVA 80MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

7) TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

8) TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP-2 REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232471		**Name**	Mrs. RAJAMANI RASABAKTHULA		
	Patient Identifier	ARHIP56310		**Age**	52Yr 5Mth 6Days
	Sex	Female		**Date of Admission**	24-Jun-2022
	Date of Discharge				
	MLC No				
	Address	8-59, GOPALRAOPET,PEDDAPALLI,Karimnagar,Telangana		**Ward/Bed No**	Second Floor, Female General Ward, Bed no:GW 7
	Primary Consultant	Dr. Vidya Sagar A--C			

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (28/06/2022) - CAD- Mid LAD -Mild Stenosis and Diagonal Ostial Stenosis

PLAN MEDICAL MANAGEMENT

R/F : HTN

C/o chest pain a/w sweating since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old female patient Mrs. RAJAMANI RASABAKTHULA came with c/o chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (28/06/2022) - CAD- Mid LAD -Mild Stenosis and Diagonal Ostial Stenosis, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. CHYMORAL FORTE **TWICE IN A DAY AT 8 AM 8 PM** FOR 3 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

Patient Identifier	ARHIP56333	**Age**	13Yr 0Mth 5Days
Sex	Male	**Date of Admission**	24-Jun-2022
Date of Discharge			
MLC No			
Address	H.NO:4-18/2,KATNEPALLY,PEDDAPALLY,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Male General Ward, Bed no:GW 21
Primary Consultant	Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	**Consultants**	
Surgeons	Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Ane
LT ORIF WITH RUSH NAILING RADIUS AND ULNA,				

CLOSED FRACTURE BOTH BONE FOREARM LEFT

SURGERY: ORIF WITH RUSH NAILING RADIUS AND ULNA DONE ON 25/06/2022

Alleged to have sustained injury due to slip and fall on 23/06/22 around 3:30 p.m, sustained injury to left forearm

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-87/min
BP-100/70mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-99%

A 13 years old male patient Mr. MATTA ASHRITH REDDY came with alleged to have sustained injury due to slip and fall on 23/06/22 around 3:30 p.m, sustained injury to left forearm. All necessary investigations were done and diagnosed as CLOSED FRACTURE BOTH BONE FOREARM LEFT, SURGERY: ORIF WITH RUSH NAILING RADIUS AND ULNA DONE ON 25/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:
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1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN SR TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYLID RD ONCE DAILY AT 8AM FOR 7 DAYS.
4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001232487		**Name**	Mr. SRINIVAS BATTULA		
	Patient Identifier	ARHIP56311		**Age**	39Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	24-Jun-2022
	Date of Discharge				
	MLC No				
	Address	28-87 CHERIYALA,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW 19
	Primary Consultant	Dr. Iftekarali (MS (Orthopaedics			

CLOSED FRACTURE BOTH BONES FOREARM RIGHT

SURGERY: ORIF WITH DCP RADIUS AND ULNA RT DONE ON 25/06/2022

Alleged to have sustained injury due to slip and fall on 24/06/22 around 7:30 p.m, sustained injury to left forearm

PHYSICAL EXAMINATION:

ON ADMISSION

---

afebrile
PR-82/min
BP-110/70mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 39 years old male patient Mr. SRINIVAS BATTULA came with alleged to have sustained injury due to slip and fall on 24/06/22 around 7:30 p.m, sustained injury to left forearm. All necessary investigations were done and diagnosed as CLOSED FRACTURE BOTH BONES FOREARM RIGHT, SURGERY: ORIF WITH DCP RADIUS AND ULNA RT DONE ON 25/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN 50 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYLID RD ONCE DAILY AT 8AM FOR 7 DAYS.
4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001230249		**Name**	Mr. M BUCHAIAH		
	Patient Identifier	ARHIP56370		**Age**	77Yr 2Mth 4Days
	Sex	Male		**Date of Admission**	27-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Jyothinagar,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:122 B
	Primary Consultant	Dr. GOUTHAM ROY (MS			

LEFT INGUINAL DIRECT HERNIA
SURGERY: LEFT INGUINAL HERNIOPLASTY DONE ON 28/06/2022

C/o swelling in left inguinal region since 1 month
K/c/o HTN, T2DM

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-86/min

BP-100/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 77 yrs old male patient Mr. BUCHAIAH came with c/o swelling in left inguinal region since 1 month. All necessary investigations done and diagnosed as LEFT INGUINAL DIRECT HERNIA , SURGERY: LEFT INGUINAL HERNIOPLASTY DONE ON 28/06/2022. Findings: 2 cm above inguinal ligament, Direct defect noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.0001232483		**Name**	Mr. SHAIK HUSSUN BEE	
Patient Identifier	ARHIP56313	**Age**	76Yr 0Mth 6Days	
Sex	Male	**Date of Admission**	24-Jun-2022	
Date of Discharge				
MLC No				
Address	Other,Other	**Ward/Bed No**	Second Floor, Female General Ward, Bed no:GW 4	

Primary Consultant	Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	**Consultants**	
Surgeons	Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56313	ARH1.000123248

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
HEMIORTHOPLASTY WITH AMP LT				

INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT

SURGERY: AMP LEFT DONE ON 25/06/2022

Alleged to have sustained injury due to slip and fall on 21/06/22, sustained injury to left hip

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-104/min
BP-100/60mmhg
RR-20/min

RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 76 years old male patient Mr. SHAIK HUSSUN BEE came with h/o alleged to have sustained injury due to slip and fall on 21/06/22, sustained injury to left hip. All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT, SURGERY: AMP LEFT DONE ON 25/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN 50 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYLID RD ONCE DAILY AT 8AM FOR 7 DAYS.
4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001174674		**Name**	Mr. RAJAM CH
Patient Identifier	ARHIP56222	**Age**	59Yr 2Mth 19Days
Sex	Male	**Date of Admission**	18-Jun-2022
Date of Discharge			
MLC No			
Address	PENCHIKALAPET,KAMANPUR,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:117 B
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE, S/P ISR OF LAD + IWMI+ LV DYS FUNCTION+ HTN

SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD] DONE ON 22/06/2022.

C/o retrosternal chest pain a/w sweating since 3 days

K/c/o HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 59 years old male patient Mr. RAJAM presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, DOUBLE VESSEL DISEASE, S/P ISR OF LAD + IWMI+ LV DYS FUNCTION+ HTN, SURGERY –CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD] DONE ON 22/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, NO PE/CLOT/VEG

BMI is 21.1 kg/m2.

Sr. Creatinine report on 23.06.2022 0.8 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

9) TAB. PROLOMET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

11) SYP. CREMAFFIN 15 ml THRICE DAILY AT 8AM 2PM 8PM .

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001232423		**Name**	Baby VARSHINI DAMA
Patient Identifier	ARHIP56284	**Age**	8Yr 0Mth 7Days
Sex	Female	**Date of Admission**	22-Jun-2022
Date of Discharge			
MLC No			
Address	KORUTLA,JAGTIAL,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:122 A
Primary Consultant	Dr SOMASHEKAR K(		

CAHD WITH OS ASD WITH L-R SHUNT WITH EMBOLISM OF ASD DEVICE IN PA
Surgery: SURGICAL CLOSURE WITH AUTOLOGUS PERICARDIAL PATCH WITH RETRIEVAL OF ASD DEVICE FROM PA DONE ON 22/06/2021.

C/o shortness of breath, palpitations for 1 month

ON ADMISSION VITAL

Patient conscious, coherent
Afebrile
PR-88/min
BP-110/70mmhg
RR-18/min
RS-BAE+,
CVS-S1S2+
P/A-Soft, BS+
SPO2-99%

A 08 years old female Baby VARSHINI DAMA presented to hospital with c/o shortness of breath, palpitations for 1 month. All necessary investigations were done and diagnosed as CAHD WITH OS ASD WITH L-R SHUNT WITH EMBOLISM OF ASD DEVICE IN PA, Surgery: SURGICAL CLOSURE WITH AUTOLOGUS PERICARDIAL PATCH WITH RETRIEVAL OF ASD DEVICE FROM PA DONE ON 22/06/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

POST ASD 2D ECHO REPORT: ASD SURGICAL CLOSURE, PATCH INSITU, NORMAL LV/RV FUNCTION, NO PE/CLOT/VEG EF-62%.

BMI is 13.8 kg/m2.

Sr. Creatinine report on 23/06/2022 0.6 mg/dl.

DISCHARGE MEDICATION
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1) TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.
2) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ROXSAFE 375 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
4) SYP ASCORIL-D ½ tsp THRICE DAILY AT 8AM 2PM 8PM

REVIEW AFTER 11 DAYS TO CTVS OPD.

ARH1.0001185733		**Name**	Mrs. A LAXMI		
	Patient Identifier	ARHIP56309		**Age**	56Yr 5Mth 28Days
	Sex	Female		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	1-10/1,KESLAPUR,Mancherial,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 6
	Primary Consultant	DR. SANJAY KUMAR KAMINWAR			

CVA-ACUTE LEFT MCA INFARCT

C/o weakness of right upper limb and lower limb, slurring of speech.

ON ADMISSION

Pt c/c/c

Afebrile

PR-98/min

BP-110/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 56 years old female patient Mrs. LAXMI presented to hospital with c/o weakness of right upper limb and lower limb, slurring of speech.. All necessary investigations were done and diagnosed as CVA-ACUTE LEFT MCA INFARCT. Patient was treated conservatively and improved symptomatically. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. PREVA AS 75MG 1TAB AT 2PM TO CONTINUE.

2) TAB. COLTRO 10MG 1TAB AT 9PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR. SANJAY KUMAR KAMINWAR OPD.

ARH1.0001232714	**Name**	Mr. SANGA ODELU			
	Patient Identifier	ARHIP56400		**Age**	50Yr 0Mth 0Days
	Sex	Male		**Date of Admission**	29-Jun-2022
	Date of Discharge				
	MLC No				
	Address	RAJARAMPALLY,VELGATUR,JAGTIAL,Karimnagar,Telangana		**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME2
	Primary Consultant	Dr. GOUTHAM ROY (MS			

LEFT TEMPORAL SEBACEOUS CYST
SURGERY: LEFT TEMPORAL SEBACEOUS CYST DONE ON DONE ON 29.06.2022

C/o swelling in left temporal region

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 50 yr old male patient Mr. SANGA ODELU came with c/o swelling in left temporal region. All necessary investigations done and diagnosed as LEFT TEMPORAL SEBACEOUS CYST, SURGERY: LEFT TEMPORAL SEBACEOUS CYST DONE ON DONE ON 29.06.2022. Findings: Cyst measuring 2 x 2 cm noted in the left temporal region. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

Identifier			0Mth 2Days
Sex	Male	**Date of Admission**	28-Jun-2022
Date of Discharge			
MLC No			
Address	RAJARAMPALLY,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 2
Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
SUICIDAL HERBICIDAL POISONING.	

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+&&&&&&&&&&&&&30/06/22&&&&&&&&&&&&&&&@@@@@@@@@@@$$$$$
$

.0001232132		**Name**	Mr. SUDDALA GANGA REDDY		
	Patient Identifier	ARHIP56255		**Age**	53Yr 0Mth 16Days
	Sex	Male		**Date of Admission**	20-Jun-2022
	Date of Discharge				
	MLC No				
	Address	GANGADHARA UPPERMALLIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 2
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH			

CRHD + SEVERE MITRAL RESTENOSIS
SURGERY: MVR WITH TTKC NO. 31 MM MECHANICAL VALVE DONE ON 24/06/2022

ON POST POD 5TH: SEPTIC SHOCK WITH NON-OLIGURIC AKI + CARDIOEMBOLIC STROKE

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 53 years old male patient Mr. SUDDALA GANGA REDDY came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CRHD + SEVERE MITRAL RESTENOSIS, SURGERY: MVR WITH TTKC NO. 31 MM MECHANICAL VALVE DONE ON 24/06/2022. ON POST POD 5TH: SEPTIC SHOCK WITH NON-OLIGURIC AKI + CARDIOEMBOLIC STROKE

0-POD: was uneventful
1st POD: patient was extubated at 6.15 AM
2nd POD : was uneventful
3rd POD : patient developed fever
Hb 7.7 gm/dl - 1 Unit PCV transfusion done Hb improved to 9.5 gm/dl
4th POD : Patient had facial weakness and unable to swallow
5th POD : patient developed left lower limb and upper limb weakness for which neurophysician consultation was done, CT was normal hence MRI brain was advised and diagnosed as cardioembolic stroke, post MVR and treated accordingly.
In view of fever, increased Sr. Urea & Creatinine, Nephrologist consultation was done and diagnosed as septic shock with non-oliguric AKI, 1 session haemodialysis done and treated accordingly.

In view of fever of unknown origin Cardiologist opinion was taken and adviced TEE for identifying mass in LA, LV, PV to rule out PV vegetations and infective endocarditis- TEE was not done.

Poor prognosis explained to the patient attendants. Patient attendants requested for discharge, hence patient is being discharged under LAMA.
Urine c/s – negative
Blood c/s report awaited

Medications given in the hospital:

INJ CLINDAMYCIN
INJ VANCOMYCIN
INJ DERIPHYLLIN
INJ STROCID
INJ PARACIP
TAB RIFAMPICIN
TAB TONACT
TAB FAMOCID
TAB ACITROM
TAB DYTOR
TAB ND VIT
TAB CARDARONE
TAB MET XL
INJ HUMAN MIXTARD
INJ POTASSIUM CHLORIDE
INJ CALCIUM
NEB WITH DUOLIN/BUDECORT

ARH1.0001232699		**Name**	Mr. DASARI RAVI
Patient Identifier	ARHIP56396	**Age**	34Yr 0Mth 2Days
Sex	Male	**Date of Admission**	28-Jun-2022
Date of Discharge			
MLC No			
Address	RAJARAMPALLY,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 2
Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
SUICIDAL HERBICIDAL POISONING.	

HERBICIDAL POISONING

Alleged history of consumption of herbicidal poisoning around 8:00 p.m. on 28/06/2022

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 34 years old male patient Mr. DASARI RAVI came with alleged history of consumption of herbicidal poisoning around 8:00 p.m. on 28/06/2022. All necessary investigations were done and diagnosed as HERBICIDAL POISONING. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharged at request.

Mr. DASARI RAVI

DISCHARGE MEDICATION:

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1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. PAN-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

3) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232609		**Name**	Mrs. MAHAMMAD SHAMEEM
Patient Identifier	ARHIP56360	**Age**	65Yr 0Mth 4Days
Sex	Female	**Date of Admission**	27-Jun-2022
Date of Discharge			
MLC No			
Address	4-74 SADAK GUDA,Adilabad(Adilabad),Telangana	**Ward/Bed No**	Second Floor, Female General Ward, Bed no:GW 11
Primary Consultant	Dr. KRISHNA CHAITANYA		

CAD, IPWMI

MINOR CAD

FAIR LV FUNCTION

NO HF

SR

C/o left side chest pain since 4-5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 64/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old female patient Mrs. MAHAMMAD SHAMEEM resented with a history of chest pain. On evaluation on Trop-T positive was diagnosed as NSTEMI. CAG done showed minor CAD. Her medications were optimised. Hence being discharged with the following medication.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN AV 75/10 ONCE IN A DAY AT 9 P.M. TO CONTINUE

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001188989		**Name**	Mr. RANGANAYAKULA RAMESH
Patient Identifier	ARHIP56362	**Age**	49Yr 2Mth 20Days
Sex	Male	**Date of Admission**	27-Jun-2022
Date of Discharge			
MLC No			
Address	9-5-193/1/A,SHIVA NAGAR,RAMNAGAR,KARIMNAGAR,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:116 B
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY	**Consultants**	

Surgeons	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56362	ARH1.000118898

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LEFT PUSH BACK PCNL AND DJ STENTING				

LEFT PROXIMAL URETERIC CALCULUS
SURGERY : LEFT PUSH BACK PCNL + DJ STENTING DONE ON 27.06.2022

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 27 yrs old male patient Mr. NILAM RAJU came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT PROXIMAL URETERIC CALCULUS, SURGERY : LEFT PUSH BACK PCNL AND DJ STENTING DONE ON 31.05.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

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1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB: VELTOM 2.4 MG ONCE DAILY AT 8PM FOR 10 DAYS
6. SYP. K-CIT 10 ML **TWICE IN A DAY AT 8 AM 8 PM**

REVIEW AFTER 7 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232591		**Name**	Mr. T RAKESH		
	Patient Identifier	ARHIP56347		**Age**	34Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	25-Jun-2022
	Date of Discharge				
	MLC No				
	Address	GATLANARSINGAPUR BHEEMADEVARAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:119 B
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

PULMONARY ARTERY HYPERTENSION

C/o shortness of breath grade-III since 2-3 days
pain abdomen
Fever with headache
chest pain associated with cough

AT ADMISSION:

Afebrile

PR: 86/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 34 years old male patient Mr. RAKESH presented with c/o shortness of breath grade-III since 2-3 days, pain abdomen, fever with headache, chest pain associated with cough. All necessary investigations were done and diagnosed as PULMONARY ARTERY HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. PAH 20 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB. BENALGIS 100 MG ONCE DAILY AT 2PM FOR 7 DAYS.
3. CAP. BEVON ONCE DAILY AT 2PM FOR 7 DAYS.
4. TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232642		**Name**	Mrs. SUGUNA MADASI		
	Patient Identifier	ARHIP56366		**Age**	62Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	27-Jun-2022
	Date of Discharge				
	MLC No				
	Address	JAMMIKUNTA,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:106 A
	Primary Consultant	Dr Chandra Shekar Sathineni			

POLYARTHRITIS

C/o multiple joint pains including temporomandibular joints

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old female patient Mrs. SUGUNA MADASI came with c/o multiple joint pains including temporomandibular joints. All necessary investigations were done and diagnosed as POLYARTHRITIS. Managed conservatively. Rheumatologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. ULTRACET TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. OMNACORTIL 5 MG ½ TAB ONCE DAILY AT 8PM FOR 7 DAYS.

3) TAB. HCQS 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

4) TAB. SHELCAL ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232544		**Name**	Mr. PRABHAKAR REDDY KARIVEDA		
	Patient Identifier	ARHIP56334		**Age**	62Yr 3Mth 0Days
	Sex	Male		**Date of Admission**	25-Jun-2022
	Date of Discharge				
	MLC No				
	Address	H*NO LAXMIDEVIPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:111 A
	Primary Consultant	Dr. SURESH GOUD S(			

BPH with increased S.PSA with AUR

C/o Gradually decreased urine output
Low backache

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. PRABHAKAR REDDY KARIVEDA came with c/o gradually decreased urine output, low backache. All necessary investigations were done and diagnosed as BPH with increased S.PSA with AUR . Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise. Trial void after 10 days, if Trial void fails, plan TURP after getting urodynamic study.

DISCHARGE MEDICATION:

---

1) TAB. FAROBACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. URIMAX-D ONCE DAILY AT 8PM FOR 15 DAYS.

3) TAB. PAN-D ONCE DAILY AT 7M BBF FOR 15 DAYS.

4) TAB. DROLGAN TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

5) TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS

6) SYP: K-CIT 10 ml TWICE DAILY AT 8AM, 8PM

REVIEW AFTER 10 DAYS IN UROLOGY OPD

ARH1.0001232214		**Name**	Mr. MALLAIAH RASAPALLI		
	Patient Identifier	ARHIP56201		**Age**	72Yr 3Mth 20Days
	Sex	Male		**Date of Admission**	16-Jun-2022
	Date of Discharge				
	MLC No				
	Address	6-57, SOMAGUDEM, BELLAMPALLY,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:105 A
	Primary Consultant	Dr. RAMCHANDER TORREM(DM			

URAEMIC ENCEPHALOPATHY
ACUTE ON CHRONIC KIDNEY DISEASE
DUODENAL ULCER
ACUTE GI BLEED
ACUTE POSTERIOR CIRCULATION STROKE
HYPERTENSION, CAD, S/P PTCA

C/o Decreased food intake,
slurring of speech
difficulty in swallowing since 10 days

AT ADMISSION:

Afebrile

PR: 58/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 14/min

SPO2: 99%

P/A: Soft

A 72 years old male patient Mr. MALLAIAH RASAPALLI came with c/o Decreased food intake, slurring of speech, difficulty in swallowing since 10 days. All necessary investigations were done and diagnosed as URAEMIC ENCEPHALOPATHY, ACUTE ON CHRONIC KIDNEY DISEASE, DUODENAL ULCER, ACUTE GI BLEED, ACUTE POSTERIOR CIRCULATION STROKE, HYPERTENSION, CAD, S/P PTCA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. FAROALFA 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. STORVAS-CV ONCE DAILY AT 2PM FOR 5 DAYS
3. TAB. KETOCHECK THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
4. TAB. CUDCE FORTE THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
5. TAB. THYRONORM 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001221028		**Name**	Mr. V SRINIVAS		
	Patient Identifier	ARHIP56393		**Age**	51Yr 9Mth 22Days
	Sex	Male		**Date of Admission**	28-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Sulthanabad,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:123 C
	Primary Consultant	Dr. RAMCHANDER TORREM			

ACUTE FEBRILE ILLNESS WITH SEPSIS

C/o Fever with chills, mild shortness of breath and abdominal discomfort

Known case of hypertension, diabetic mellitus, CKD on haemodialysis
History of right lower limb cellulitis

AT ADMISSION:

PR: 130/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 51 years old male patient Mr. SRINIVAS came with c/o fever with chills, mild shortness of breath and abdominal discomfort. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS WITH SEPSIS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. GLEVO 500 MG ONCE DAILY AT 2PM FOR 5 DAYS
3. TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
4. TAB. CILACAR M 10/50 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. DYTOR 40 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. CALCI-CZ ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. GEROZ-LP **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001221643		**Name**	Mr. SATYANARAYANA SAMALA		
	Patient Identifier	ARHIP56306		**Age**	72Yr 9Mth 11Days
	Sex	Male		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	H.NO:9-8-99,T.R.NAGAR,SIRICILLA,RAJANNA SIRICILLA,Other,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:115 A
	Primary Consultant	Dr Chandra Shekar Sathineni			

LOWER RESPIRATORY TRACT INFECTION
RENAL INSUFFICIENCY
DIABETIC MELLITUS

C/o Shortness of breath grade- 3 to 4 since 1 day associated with cough

Known case of CAD s/p CABG in 09/2021
T2DM, HTN, AKI

AT ADMISSION:

Afebrile

PR: 160/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 72 years old male patient Mr. SATYANARAYANA SAMALA came with c/o shortness of breath grade- 3 to 4 since 1 day associated with cough. Known case of CAD s/p CABG in 09/2021, T2DM, HTN, AKI. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION, RENAL INSUFFICIENCY, DIABETIC MELLITUS. Managed conservatively. Patient

condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. SOBISIS FORTE TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

4) INJ. LANTUS 20 UNITS ONCE DAILY AT 8PM FOR 7 DAYS

5) TAB. GEROZ-LP ONCE DAILY AT 8PM FOR 10 DAYS

6) TAB. DYTOR PLUS 20 MG ONCE DAILY AT 8AM FOR 10 DAYS

7) TAB. RENOSAVE ONCE DAILY AT 2PM FOR 7 DAYS

8) TAB. ECOSPRIN AV 150/20 ONCE DAILY AT 8PM FOR 15 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001178051	**Name**	Mr. PYDAKULA MALLAIAH			
	Patient Identifier	ARHIP56293		**Age**	67Yr 3Mth 0Days
	Sex	Male		**Date of Admission**	23-Jun-2022
	Date of Discharge				
	MLC No				
	Address	2-96/1,RAMANNAPALLI,JAMMIKUNTA,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:118 C
	Primary Consultant	Dr Chandra Shekar Sathineni			

RIGHT KNEE OSTEOARTHRITIS
CERVICAL SPONDYLOSIS

C/o bilateral paraesthesia, numbness since 3-4 days
Generalised weakness

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 86/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 67 years old male patient Mr. PYDAKULA MALLAIAH came with c/o bilateral paraesthesia, numbness since 3-4 days, generalised weakness. All necessary investigations were done and diagnosed as RIGHT KNEE OSTEOARTHRITIS,

CERVICAL SPONDYLOSIS. Managed conservatively. Psychiatrist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ROSELUPIN ONCE DAILY AT 8AM FOR 7 DAYS
2. TAB. NOOTROPIL ONCE DAILY AT 2PM FOR 7 DAYS
3. TAB. LARIGABA NT TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
4. TAB. DONEP 5 MG ONCE DAILY AT 8AM FOR 7 DAYS
5. TAB. QUITIPIN 25 MG ONCE DAILY AT 8PM FOR 7 DAYS
6. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
7. SYP. PREGALUP 15 ml TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232393		**Name**	Mrs. VIJAYA LAXMI		
	Patient Identifier	ARHIP56392		**Age**	60Yr 0Mth 9Days
	Sex	Female		**Date of Admission**	28-Jun-2022
	Date of Discharge				
	MLC No				
	Address	Godavarikhani Peddapalli,Ramagundam,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
	Primary Consultant	Dr. KRISHNA CHAITANYA M (MD			

CORONARY ARTERY DISEASE , AWSTEMI
SEVERE LV DYSFUNCTION,
PULMONARY EDEMA
CARDIOGENIC SHOCK
HEART FAILURE - CONTROLLED.
FC-IV
SINUS RHYTHM
CORONARY ANGIOGRAM DONE ON 21/06/2022 – CRITICAL-LM+TVD
CARDIAC VIABILITY: MRI: 50% VIABLE MYOCARDIUM IN LAD TERRITORY
PLAN: CABG

C/o sudden onset chest pain since 1 day

At Admission

Afebrile
PR: 65/min
BP: 110/70 mmHg
RR-20/min
RS: BAE+
CVS: S1S2
P/A: Soft
SPO2-86%

A 60 years old female patient Mrs. VIJAYA LAXMI was admitted for stabilization of breathing difficulty, she was planned for CABG. Hence, being discharged for CABG with the following medication.

DISCHARGE MEDICATION:

---

1. TAB. ATORVA 40 MG ONCE DAILY AT 9PM TO CONTINUE.
2. TAB. RANOZEX 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. MET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
5. TAB. IVABID 5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. TAB. FRUSELAC DS (40/50) TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. TAB. RAMISTAR 2.5MG ONCE DAILY AT 8AM TO CONTINUE.
8. INJ HUMAN ACTRAPOD S/C 8/5 THRICE DAILY AT 8AM 2PM 8PM
9. INJ HEPARIN 5000 Units IV 6^{th} hrly

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001232660	**Name**	Mrs. RAJA KUMARI RADHARAPU			
	Patient Identifier	ARHIP56374		**Age**	65Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	27-Jun-2022
	Date of Discharge				
	MLC No				
	Address	13-3-432/2,THILAKNAGAR,GODAVARIKHANI,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:106 B
	Primary Consultant	DR. SRI KARAN UDDESH			

ACUTE ON CHRONIC KIDNEY DISEASE

C/o bilateral pedal oedema since 2 months

H/o facial puffiness since 1 month

Known case of diabetic mellitus hypertension and hypothyroidism on treatment

History of appendicectomy 20 years ago

AT ADMISSION:

PR: 97/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft, b/l- pitting pedal edema

A 65 years old male patient Mrs. RAJA KUMARI RADHARAPU presented with the above-mentioned complaints, patient was suspected to have chronic kidney disease. Workup revealed hyperurecemia, hyperphosphataemia and anaemia of chronic kidney disease, patient was treated with diuretics and CALCIUM supplementation and FEBUGET. Patient is now symptomatically better and he is hence being discharged with following advice.

DISCHARGE MEDICATION:

---

1. TAB. PAN 40 MG ONCE **IN A DAY AT 7AM** FOR 7 DAYS
2. TAB. SHELCAL-O ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
3. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
4. TAB. THYRONORM 50 MCG ONCE **IN A DAY AT 8 AM** TO CONTINUE
5. TAB. FEBUGUT ONCE **IN A DAY AT 8 AM** FOR 7 DAYS
6. TAB. TELMA 20 MG ONCE **IN A DAY AT 8 AM** TO CONTINUE
7. TAB. DYTOR 20 MG ONCE **IN A DAY AT 8 AM** FOR 7 DAYS

REVIEW IN GENERAL MEDICINE OPD WITH FASTING BLOOD SUGAR AND POST PRANDIAL BLOOD GLUCOSE LEVELS AFTER 7 DAYS ALONG WITH RP -2

ARH1.0001232528		**Name**	Mr. K CHANDRAIAH
Patient Identifier	ARHIP56329	**Age**	65Yr 0Mth 6Days
Sex	Male	**Date of Admission**	24-Jun-2022
Date of Discharge			
MLC No			
Address	CHINNAKALVALA,SULTHANABAD,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Male General Ward, Bed no:GW 23
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

CVA - ACUTE ISCHAEMIC STROKE
CAD

C/o left sided weakness, slurring of speech and deviation of mouth

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 72/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old male patient CHANDRAIAH came with c/o left sided weakness, slurring of speech and deviation of mouth. All necessary investigations were done and diagnosed as CVA - ACUTE ISCHAEMIC STROKE, CAD. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM FOR11 DAYS
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM FOR 11 DAYS
3. TAB. ATORVA 40 MG ONCE DAILY AT 8PM FOR 11 DAYS
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.0001232666		**Name**	Mr. SRINIVASCH
Patient Identifier	ARHIP56384	**Age**	57Yr 0Mth 3Days
Sex	Male	**Date of Admission**	27-Jun-2022
Date of Discharge			
MLC No			
Address	7-1-243 MANKAMATHOTHA,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 2
Primary Consultant	DR. SUBRAT KUMAR SOREN		

RTA - TRAUMATIC BRAIN INJURY
FRONTAL LOBE CONTUSIONS
CHRONIC KIDNEY DISEASE
ACUTE DELIRIUM TREMENS

Alleged to have sustained injury due to RTA 2 wheeler Vs 2 wheeler on 27/06/2022 around 10.30 AM
H/o LOC, Oral bleed+

Known case of HTN, T2DM

AT ADMISSION:

Patient c/c

PR: 87/min

BP: 160/110mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 90%

P/A: Soft, BS+

GCS- 15/15

A 57 years old male patient SRINIVAS came with alleged to have sustained injury due to RTA 2 wheeler Vs 2 wheeler on 27/06/2022 around 10.30 AM, h/o LOC, Oral bleed+. All necessary investigations were done and diagnosed as RTA - TRAUMATIC BRAIN INJURY, FRONTAL LOBE CONTUSIONS, CHRONIC KIDNEY DISEASE, ACUTE DELIRIUM TREMENS. Managed conservatively. Nephrology consultation was taken due to the raised Sr. Creatinine level and advice followed. Psychiatrist consultation was taken due to agitated behaviour of patient and advice followed. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. BREVIPIL 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
2. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 7 DAYS.
3. TAB. ANXOZAP (OXAZEPAM) 10 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
4. TAB. QUITIAPIN 25 MG ONCE DAILY AT 8PM FOR 7 DAYS.
5. TAB. THIAMINE 10 MG ONCE DAILY AT 2PM FOR 7 DAYS.
6. TAB. SOBINIX 500 MG ONCE DAILY AT 2PM FOR 7 DAYS.
7. TAB. TELISTA AM ONCE DAILY AT 8AM FOR 7 DAYS.
8. TAB. GLUCORYL-MVS ONCE DAILY AT 8AM FOR 7 DAYS.

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001232750		**Name**	Mr. N RAVINDAR		
	Patient Identifier	ARHIP56416		**Age**	55Yr 0Mth 0Days
	Sex	Male		**Date of Admission**	30-Jun-2022
	Date of Discharge				
	MLC No				
	Address	RAMANNAPET,Sircilla,Telangana		**Ward/ Bed No**	First Floor, Day Care, Bed no:DC 6
	Primary Consultant	Dr. KRISHNA CHAITANYA			

CAG- MINOR CAD

C/o giddiness, vomitings since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. RAVINDER presented with history of giddiness. CAG done showed minor CAD. His medications were optimised. Hence being discharged with the following medication.

DISCHARGE MEDICATION:

1. TAB. ROZUVAS 10 MG ONCE IN A DAY AT 9 P.M. TO CONTINUE

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232583		**Name**	Mrs. CHINNA MALLAMMA KONDRA
Patient Identifier	ARHIP56340	**Age**	76Yr 5Mth 5Days
Sex	Female	**Date of Admission**	25-Jun-2022
Date of Discharge			
MLC No			
Address	4-591, KODURUPAKA,PEDDAPALLI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
Primary Consultant	Dr. KRISHNA CHAITANYA		

VALVULAR HEART DISEASE
SEVERE AORTIC REGURGITATION
NO HF
SR
AORTIC ROOF ANGIOGRAM -SEVERE AORTIC REGURGITATION

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 76 years old female patient Mrs. CHINNA MALLAMMA KONDRA presented with complaint of dyspnoea giddiness on evaluation ECG showed a beginning echo showed moderate to severe aortic regurgitation CAG done which showed normal coronaries aortic roof angiogram showed severe aortic regurgitation. Patient was planned aortic valve replacement. Hence being discharged with the following medication.

DISCHARGE MEDICATION:

1. TAB. FRUSELAC-DS ½ TAB ONCE IN A DAY AT 8 AM TO CONTINUE
2. TAB. RAMISTAR 2.5 MG ONCE IN A DAY AT 8 AM TO CONTINUE

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232640		**Name**	Mr. R ANJAIAH
Patient Identifier	ARHIP56373	**Age**	50Yr 8Mth 5Days
Sex	Male	**Date of Admission**	27-Jun-2022
Date of Discharge			
MLC No			
Address	1-29,KACHIREDDIPALLE, GANGADHARA,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU13
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

MILD LV SYSTOLIC DYSFUNCTION, SR

CORONARY ANGIOGRAM DONE ON 27/06/2022 – CAD-DVD (RCA, LCX)

PTCA+DES TO RCA, OM2 (2 STENTS) RCA WITH 3.0 X 33 MM XIENCE XPEDITION, OM2 WITH 2.75 X 18 MM XIENCE XPEDITION DONE ON 28/06/2022

C/o chest pain since 2 days associated with fever

AT ADMISSION:

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 50 years old male patient Mr. ANJAIAH came with c/o chest pain since 2 days associated with fever . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV SYSTOLIC DYSFUNCTION, SR , CORONARY ANGIOGRAM DONE ON 27/06/2022 – CAD-DVD (RCA, LCX), PTCA+DES TO RCA, OM2 (2 STENTS) RCA WITH 3.0 X 33 MM XIENCE XPEDITION, OM2 WITH 2.75 X 18 MM XIENCE XPEDITION DONE ON 28/06/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. NOVASTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. METOLAR XR 25MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232492	**Name**	Mr. RAJESHAM VASAM			
	Patient Identifier	ARHIP56315		**Age**	53Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	24-Jun-2022
	Date of Discharge				
	MLC No				
	Address	H.NO:1-38/1,MUNJAMPALLY,KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. KRISHNA CHAITANYA M (			

CAD AWSTEMI, MILD MODERATE LV DYSFUNCTION

CONTROLLED HF, SR

CARDIOGENIC SHOCK
AKI ON CKD
DIABETES MELLITUS

Complaint of chest pain and breathing difficulty

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old male patient Mr. RAJESHAM VASAM presented with complaint of chest pain and breathing difficulty, on evaluation. STEMI with aVR ST elevation suggestive LMCA or critical TVD. CAG done showed LMCA + TVD. He was stabilised . His renal parameters deranged secondary to cardiogenic shock. Diabetic nephropathy. He was stabilised with IV medication. Family were explained about high risk for CABG. In view of renal dysfunction. Risk for sudden cardiac arrest explained to family members. He is being discharged with following medication

DISCHARGE MEDICATION:

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1. TAB. AZTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
3. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. FLAVEDON MR 35MG **THRICE IN A DAY AT 8 AM 2PM 8 PM** TO CONTINUE.
5. TAB. RENOSAVE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. VELTAM 0.2 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232651		**Name**	Mrs. BHUMAKKA APPANI		
	Patient Identifier	ARHIP56371		**Age**	70Yr 0Mth 4Days
	Sex	Female		**Date of Admission**	27-Jun-2022
	Date of Discharge				
	MLC No				
	Address	NAMNOOR, HAZIPUR, MANCHERIAL,Tandur,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU10
	Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI

MILD LV SYSTOLIC DYSFUNCTION, EF-45%, SR

CAG-DVD ON 28/06/2022

PTCA TO LAD, LCX [2 STENTS] LAD WITH XIENCE XPEDITION 2.75 X 33 MM, LCX WITH XIENCE XPEDITION 2.75 X 33 MM DONE ON 28/06/2022

C/o chest pain associated with SOB since 1 day

K/c/o Hypertension

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 70 years old woman Mrs. BHUMAKKA presented with complaint of chest pain on evaluation, diagnosed to have NSTEMI, mild LV dysfunction, SR, coronary angiogram done showed LAD and LCX regions. PTCA to LCX thrombotic total occlusion and LAD done. Good result. TIMI-III flow. She is symptomatically better and haemodynamically stable, hence being discharged with following advice.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM, 8 PM** TO CONTINUE.
3. TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM**
5. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. LASIX 40 MG ½ TAB ONCE DAILY AT 8 AM TO CONTINUE.
7. TAB. ALDACTONE 50 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 2 PM** TO CONTINUE.
9. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP-2 Reports

GANGAMMA

ARH1.0001232499		**Name**	Mrs. GANGAMMA PALEPU
Patient Identifier	ARHIP56319	**Age**	55Yr 11Mth 7Days
Sex	Female	**Date of Admission**	24-Jun-2022
Date of Discharge			
MLC No			
Address	2-72/1,THIMMAPUR,JAGTIAL,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

COMPLETE HEART BLOCK
CORONARY ARTERY DISEASE

MODERATE AR/MR/MILD TR/PAH

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM (24/06/2022) -PROXIMAL LAD MILD STENOSIS

TPI DONE ON 27/06/2022
PPI DONE ON 27/06/2022 WITH MEDTRONIC [VVIR]

C/o chest pain radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 78/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 55years old female patient Mrs. GANGAMMA PALEPU came with c/o chest pain radiating to back since 1 day. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK, CORONARY ARTERY DISEASE, AWMI, MODERATE AR/MR/MILD TR/PAH, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM (24/06/2022) -PROXIMAL LAD MILD STENOSIS, TPI DONE ON 27/06/2022, PPI DONE ON 27/06/2022 WITH MEDTRONIC [VVIR] . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. TONACT 20 MG **ONCE IN A DAY AT 8 PM AFTER DINNER** FOR 7 DAYS

2) TAB. AUGMENTIN DUO 625MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

3) TAB. CHYMORAL FORTE **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS

4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

5) TAB. BEPLEX FORTE ONCE DAILY AT 2PM FOR 10 DAYS

6) SYP. ASCORYL-D 10 ml **TWICE IN A DAY AT 8 AM 8 PM**

7) T-BACT OINTMENT FOR L/A

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232761		**Name**	Mrs. RAJAMMA G		
	Patient Identifier	ARHIP56419		**Age**	45Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	30-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KATKUR, ,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 7
	Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY			

ACUTE FISSURE IN ANO WITH
SURGERY: EVA LORD’S DILATATION + LATERAL SPHINCTEROTOMY DONE ON 30/06/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-110/60mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 45 yrs old female patient RAJAMMA came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as ACUTE FISSURE IN ANO, SURGERY: EVA LORD'S DILATATION + LATERAL SPHINCTEROTOMY DONE ON 30/06/2022. Findings: Posterior fissure with severe anal spasm, sentinel pile noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
3. GLUTAVAULT –V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4th hrly
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. SITZ BAH TWICE DAILY

Review after 7 days in General Surgery OPD.

ARH1.0001232403			**Name**	Mr. K RAMULU	
Patient Identifier	ARHIP56274			**Age**	75Yr 0Mth 3Days
Sex	Male			**Date of Admission**	21-Jun-2022
Expired Date	24-Jun-2022				
MLC No					
Address	RAMNAGAR KARIMNAGAR,Karimnagar,Telangana			**Ward/Bed No**	First Floor, CICU , Bed no:CICU 1

Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**
Surgeons		**Anesthesiologists**

Diagnosis

Diagnosis

Disease	Disease Type
ISCHEMIC CARDIO MYOPATHMY,VENTRICULAR TACHYCARDIA,ACUTE KIDNEY INJURY.	

C/o chest pain since 2 days

AT ADMISSION:
PR: 72/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 75 years old male patient RAMULU came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as ISCHEMIC CARDIO MYOPATHMY,VENTRICULAR TACHYCARDIA,ACUTE KIDNEY INJURY. Poor prognosis explained to the patient attendants, suddenly patient unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.36 PM on 24/06/2022.

CAUSE OF DEATH

SUDDEN CARDIORESPIRATORY ARREST SECONDARY TO ISCHEMIC CARDIO MYOPATHMY,VENTRICULAR TACHYCARDIA,ACUTE KIDNEY INJURY

ARH1.0001231920	**Name**	Mr. PARSHARAM KAVVAMPALLY			
	Patient Identifier	ARHIP56304		**Age**	52Yr 0Mth 17Days
	Sex	Male		**Date of Admission**	23-Jun-2022
	Expired Date	26-Jun-2022			
	MLC No				
	Address	GANNERVARAM,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU 7
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
LATE STENT THROMBOSIS,PTCA TO DOUBLE STENT TO LAD,ACUTE PULMONARY EDEMA,ACUTE RENAL FAILURE	

C/o chest pain a/w SOB since 1 day

AT ADMISSION:
PR: 20/min
BP: 130/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 52 years old male patient Mr. PARSHARAM KAVVAMPALLY came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as LATE STENT THROMBOSIS,PTCA TO DOUBLE STENT TO LAD,ACUTE PULMONARY EDEMA,ACUTE RENAL FAILURE. Poor prognosis explained to the patient attendants, suddenly patient

became unconscious. INJ. Atropine and INJ. ADRENALINE given, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.14 AM on 26/06/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO LATE STENT THROMBOSIS,PTCA TO DOUBLE STENT TO LAD,ACUTE PULMONARY EDEMA,ACUTE RENAL FAILURE

ARH1.0001144725		**Name**	Mrs. GUMMULA RAJAVVA		
	Patient Identifier	ARHIP56368		**Age**	69Yr 7Mth 12Days
	Sex	Female		**Date of Admission**	27-Jun-2022
	Date of Discharge				
	MLC No				
	Address	VELAGATOOR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar			

CORONARY ARTERY DISEASE, ACUTE AWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

AF ON CARDARONE INJECTION -->SR

CORONARY ANGIOGRAM DONE ON 27/06/2022 – CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 27/06/2022
ACUTE PULMONARY OEDEMA [RECOVERED]
R/F: HTN

C/o chest pain since 1 day associated with vomitings

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 69 years old female patient Mrs. GUMMULA RAJAVVA came with c/o chest pain since 1 day associated with vomitings . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, AF ON CARDARONE INJECTION -->SR , CORONARY ANGIOGRAM DONE ON 27/06/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 27/06/2022, ACUTE PULMONARY OEDEMA [RECOVERED]. Patient developed AF on 28/06/22 - reverted to SR on CORDARONE INJ. And another episode of atrial flutter developed on 02/07/22 on CORDARONE INJ. Reverted to SR, Acute pulmonary oedema [recovered]. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. ACITROM 1 MG ONCE DAILY AT 4PM TO CONTINUE.

4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. CORDARONEX 200 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. METOLAR XR 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

7) TAB. DYTOR PLUS ONCE DAILY AT 8AM TO CONTINUE.

8) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH PT, INR, CBC

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232806		**Name**	Mrs. NEELAM MUNEMMA		
	Patient Identifier	ARHIP56443		**Age**	60Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	THIRUMALAPUR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 11
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY			

C/o shortness of breath grade-3 since few days, drowsiness+

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/870mmHg

RS: BAE+

CVS: S1S2

RR: 17/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. NEELAM MUNEMMA came with c/o shortness of breath grade-3 since few days, drowsiness+. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY WITH HPERKALEMIA. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001232043		**Name**	Mrs. PREAMALATHA G
Patient Identifier	ARHIP56204	**Age**	69Yr 0Mth 19Days
Sex	Female	**Date of Admission**	17-Jun-2022
Date of Discharge	28-Jun-2022		
MLC No			
Address	11-2-303 INDIRA NAGAR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CT POST, Bed no:CT 3
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Consultants**	
Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Disease	Disease Type

CORONARY ARTERY DISEASE +TRIPLE VESSEL DISEASE+LV DYSFUNCTION+HYPERTENSION+STATUS POST AWMI

SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 21/06/2022

C/o chest pain since 3 days

AT ADMISSION:

PR: 89/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 69 years old female patient Mrs. PREMALATHA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE +TRIPLE VESSEL DISEASE+LV DYSFUNCTION+HYPERTENSION+STATUS POST AWMI, SURGERY –CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 21/06/2022. Poor prognosis explained to the patient attendants, suddenly

patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 11.30 AM on 28/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEPTIC SHOCK, LOW CARDIAC OUTPUT, LV DYSFUNCTION, K/C/O CAD, S/P CABG

ARH1.0001232744		**Name**	Ms. NAVAYASRI MAVURAM
Patient Identifier	ARHIP56412	**Age**	28Yr 1Mth 22Days
Sex	Female	**Date of Admission**	30-Jun-2022
Date of Discharge			
MLC No			
Address	KMR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 1
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56412	ARH1.000123274

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists

LAPROSCOPIC CHOLECYSTECTOMY

ACUTE CALCULUS CHOLECYSTITIS WITH PASSED CBD CALCULUS
SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.07.2022

C/o pain abdomen since 5 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 28 yrs old female patient Ms. NAVAYASRI MAVURAM came with c/o pain abdomen since 5 days. All necessary investigations done and diagnosed as ACUTE CALCULUS CHOLECYSTITIS WITH PASSED CBD CALCULUS, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 01.07.2022. Findings: Well distended gallbladder with well defined calot's. Inflammatory changes noted with mild wall thickening. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. TAB: VSL-3 ONCE DAILY AT 2PM FOR 15 DAYS.
6. GLUTAWAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001232806	**Name**	Mrs. NEELAM MUNEMMA		
	Patient Identifier	ARHIP56443	**Age**	60Yr 0Mth 1Days
	Sex	Female	**Date of Admission**	01-Jul-2022
	Date of Discharge			
	MLC No			
	Address	THIRUMALAPUR,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 11
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY	**Consultants**	
	Surgeons			

ACUTE LEFT MCA INFARCT
POST THROMBOLISATION WITH INJ. TENECTEPLASE

C/o sudden onset of slurring of speech since 11:30 a.m. on 01/07/22
History of LOC +

AT ADMISSION:

Afebrile

PR: 90/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. NEELAM MUNEMMA came with c/o sudden onset of slurring of speech since 11:30 a.m. on 01/07/22, history of LOC +. All necessary investigations were done and diagnosed as ACUTE LEFT MCA INFARCT, POST THROMBOLISATION WITH INJ. TENECTEPLASE. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. Patient not willing for CT-Scan to restart antiplatlets.

ARH1.0001099939		**Name**	Mrs. GADDI RENUKA		
	Patient Identifier	ARHIP56431		**Age**	36Yr 4Mth 12Days
	Sex	Female		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	THIMMAPUR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 3
	Primary Consultant	Dr. GOUTHAM ROY			

ACUTE INTESTINAL OBSTRUCTION

C/o pain abdomen

H/o nausea with 2 episodes of vomiting

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 36 years old female patient Mrs. GADDI RENUKA came with c/o pain abdomen, h/o nausea with 2 episodes of vomiting. All necessary investigations were done and diagnosed as ACUTE INTESTINAL OBSTRUCTION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1) TAB. ORNI-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS

2) TAB. VSL-3 ONCE DAILY AT 2PM FOR 10 DAYS

3) TAB. SOMPREZ-L **TWICE IN A DAY AT 8 AM** AND **8 PM** FOR 10 DAYS

4) SYP. LACTIFIBER 2 tsp TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 7 DAYS IN GENERAL SURGERY OPD

ARH1.0001226096	**Name**	Mrs. K NARSAMMA			
	Patient Identifier	ARHIP56418		**Age**	69Yr 6Mth 2Days
	Sex	Female		**Date of Admission**	30-Jun-2022
	Expired Date	02-Jul-2022			
	MLC No				
	Address	Sircilla,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 5
	Primary Consultant	DR. NIKHIL GOLI -- NEUROLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Cause of Death

Cause of Death



Diagnosis

Diagnosis

Disease	Disease Type
SEPSIS WITH AKI RIGHT EAR MALIGNANT AND MULTIPLE CRANIAL NERVE PALSY.	

C/o slurring of speech, altered sensorium,
H/o fever, nausea, vomiting

K/c/o HTN, T2DM, Rt ear malignant

AT ADMISSION:

PR: 120/min

BP: 150/90 mmHg

CVS: S1S2

RR: 20/min

SPO2: 96% with 6 Litr O2

P/A: Soft, BS+

A 69 years old female patient Mrs. K NARSAMMA came with c/o slurring of speech, altered sensorium, h/o fever, nausea, vomiting. All necessary investigations were done and diagnosed as SEPSIS WITH AKI, RIGHT EAR MALIGNANT AND MULTIPLE CRANIAL NERVE PALSY. Poor prognosis explained to patient attendants. Patient had sinus badycardia and decrased heart rate. Patient was intubated and connected to mechanical ventilator support on SIMV mode with fio2-100%. Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.18 pm on 02/07/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH AKI
RIGHT EAR MALIGNANT AND MULTIPLE CRANIAL NERVE PALSY.

APJ1.0001475650		**Name**	Mrs. KOMAMARAMMA CH
Patient Identifier	ARHIP56356	**Age**	70Yr 1Mth 27Days
Sex	Female	**Date of Admission**	26-Jun-2022
Date of Discharge			
MLC No			
Address	10-4-216, VAVILAPALLY,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ACUTE DECOMPENSATED HEART FAILURE
OLD HISTORY OF CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MI,
ACUTE PULMONARY OEDEMA
SEVERE LV DYSFUNCTION, EF-30%. BRONCHIECTASIS, SEPSIS
R/F DIABETES MELLITUS TYPE2

C/o Shortness of breath grade-3 since 2-3 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-85/min

BP-120/70mmhg

RR-19/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 70 years old female patient Mrs. KOMAMARAMMA CH presented to with C/o Shortness of breath grade-3 since 2-3 days associated with a cough. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, OLD HISTORY OF CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MI, ACUTE PULMONARY OEDEMA, SEVERE LV DYSFUNCTION, EF-30%. BRONCHIECTASIS, SEPSIS
R/F DIABETES MELLITUS TYPE2. Patient suddenly developed respiratory distress needing NIV and O2 support and managed conservatively. Pulmonologist consultation taken and advice followed. As patient is anaemic, Hb is 8.5, 1 unit PRBC blood transfusion done and Hb improved to 9.6 mg/dL. Patient's condition and the need for further hospitalisation explained to patient attendants but patient attendants requested for discharge hence, patient being discharged at request.

DISCHARGE MEDICATION:

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1) TAB.ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB.CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB.ATORVA 40MG ONCE DAILY AT 9PM TO CONTINUE.

4) TAB.DILZEM SR 90MG ONCE DAILY AT 8AM TO CONTINUE.

5) INJ.HUMAN INSULATARD S/C 8 U TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

6) TAB.DYTOR PLUS 20MG ONCE DAILY AT 8PM TO CONTINUE.

7) TAB.PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

8) SYP.CREMAFFIN 10 ML ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIOLOGY OPD WITH FBS, PLBS REPORTS.

56432

ARH1.0001197671	**Name**	Mr. K V HANUMANTHA RAO			
	Patient Identifier	ARHIP56432		**Age**	89Yr 10Mth 2Days
	Sex	Male		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	CRITAIN COLONY, KARIMNAGAR,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 6
	Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

ACUTE CEREBELLAR HAEMORRHAGIC INFARCT.

C/o sudden onset of vomiting since 1 day
known case of CVA, left hemiparesis

H/o Bilateral knee replacement 6 years back

AT ADMISSION:

Afebrile

PR: 83/min

BP: 190/110 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft,

A 89 years old male patient HANUMANTHA RAO came with c/o sudden onset of vomiting since 1 day, known case of CVA, left hemiparesis, h/o Bilateral knee replacement 6 years back. All necessary investigations were done and diagnosed as ACUTE CEREBELLAR HAEMORRHAGIC INFARCT. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. Referred to higher center for further management.

ARH1.0001232811	**Name**	Mrs. AJMERA NEELABAI			
	Patient Identifier	ARHIP56442		**Age**	58Yr 1Mth 3Days
	Sex	Female		**Date of Admission**	01-Jul-2022
	Date of Discharge	03-Jul-2022			
	MLC No				
	Address	3-97,LAMBADITHANDA,GURJAL,BELLAMPALLE,MANCHERIAL-8106466674,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CAD-NSTEMI,NORMSL LV SYSTOLIC FUNCTION (EF-60%)SR S/P;CAD-LM+TVD(LAD,LCX,RCA)DONE ON 02/07/2022 PLAN;CABG R/F;HYPERTENSION,TYPE2DM,TOBACCO(SNUFFING)	

CAD-NSTEMI,NORMSL LV SYSTOLIC FUNCTION (EF-60%)SR
S/P;CAD-LM+TVD(LAD,LCX,RCA)DONE ON 02/07/2022
PLAN;CABG
R/F;HYPERTENSION,TYPE2DM,TOBACCO(SNUFFING)

C/o sudden onset chest pain a/w profuse sweating since 2 days

K/c/o Hypertension,TYPE2 DM,Tobacco(snuffing)

At Admission

Afebrile

PR: 73/min

BP: 120/70 mmHg

RR-22/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 58 years old female patient Mrs. AJMERA NEELABAI came with c/o sudden onset chest pain a/w profuse sweating since 2 days. All necessary investigations were done and

diagnosed as CAD-NSTEMI,NORMSL LV SYSTOLIC FUNCTION (EF-60%)SR, S/P;CAD-LM+TVD(LAD,LCX,RCA)DONE ON 02/07/2022, PLAN;CABG. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. At the time of discharge PR-84 min, BP-120/60 mmHg, SPO2-97% on room air.

ARH1.0001232742	**Name**	Mrs. SAMMAKKA LINGALA		
	Patient Identifier	ARHIP56411	**Age**	77Yr 0Mth 5Days
	Sex	Female	**Date of Admission**	30-Jun-2022
	Date of Discharge	03-Jul-2022		
	MLC No			
	Address	H.NO:21-3-5,RADAGAMBALA BASTHI,BELLAMAPALLY,Mancherial,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

⊟ Diagnosis

Diagnosis

Disease	Disease Type
CAD-AWMI,MODERATE LV SYSTOLIC DYSFUNCTION(EF;35%)SR S/P;CAG DONE ON(01/07/202)CAD-LM+DVD(LAD,RCA) PLAN;CABG K/C/O-BRONCHIAL ASTHAMA,HTN	

C/o sudden onset chest pain a/w mild sweating, SOB since 1 day

K/c/o Hypertension,Bronchial asthma

At Admission

Afebrile

PR: 81/min

BP: 120/70 mmHg

RR-22/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 77 years old female patient Mrs. SAMMAKKA LINGALA came with c/o sudden onset chest pain a/w mild sweating, SOB since 1 day. All necessary investigations were done and diagnosed as CAD-AWMI,MODERATE LV SYSTOLIC DYSFUNCTION(EF;35%)SR, S/P;CAG DONE ON(01/07/202)CAD-LM+DVD(LAD,RCA), PLAN;CABG, Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA. At the time of discharge PR-91 min, BP-110/70 mmHg, SPO2-98% on room air.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5. TAB. RAMISTAR 1.25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.

.0001232771	**Name**	Mrs. V RAJESHWARI		
	Patient Identifier	ARHIP56420	**Age**	65Yr 0Mth 4Days
	Sex	Female	**Date of Admission**	30-Jun-2022
	Date of Discharge	03-Jul-2022		
	MLC No			
	Address	GODAVARIKHANI PEDDAPALLI ,Ramagundam,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 9
	Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	**Consultants**	
	Surgeons	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CAD;UNSTABLE ANGINA,NORMAL LVFUNCTION,NO HF,SR
CAG;LAD MID80%FOLLOWED BY DISTAL 70%STENOSIS
PTCA TO LAD WITH 2.5X28MM XIENCE &2.25X15MM XIENCE (30/06/2022) GOOD RESULT.
K/C/O-TYPE2DM

C/o chest pain on and off since 3 days

AT ADMISSION:

Afebrile

PR: 94/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 65 years old female patient Mrs. V RAJESHWARI came with c/o chest pain on and off since 3 days. All necessary investigations were done and diagnosed as CAD;UNSTABLE ANGINA,NORMAL LVFUNCTION,NO HF,SR, CAG;LAD MID80%FOLLOWED BY DISTAL 70%STENOSIS, PTCA TO LAD WITH 2.5X28MM XIENCE &2.25X15MM XIENCE (30/06/2022) GOOD RESULT. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
5. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. SYP. LACTIFIBRE 15 ml ONCE DAILY AT 8PM TO CONTINUE.
9. TAB. INTAGLIP-M 50/500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH CBC, RP2 REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232813	**Name**	Ms. KAMALAMMA PERAMANDLA			
	Patient Identifier	ARHIP56444		**Age**	62Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	Other,Other		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 8
	Primary Consultant	DR. NIKHIL GOLI -- NEUROLOGY			

ACUTE INFARCT IN RIGHT MCA
ASPIRATION PNEUMONIA

C/o sudden onset of left sided weakness, slurring of speech
History of aphasia, altered sensorium

At Admission

PR: 100/min

BP: 90/60 mmHg

RR-18/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98% with FIO2 80%

A 62 years old female patient Ms. KAMALAMMA PERAMANDLA came with c/o sudden onset of left sided weakness, slurring of speech, history of aphasia, altered sensorium . All necessary investigations were done and diagnosed as ACUTE INFARCT IN RIGHT MCA, ASPIRATION PNEUMONIA . Managed conservatively. On 03/07/2022 at 8.20 AM patient had bradycardia, CPR started Inj ADRENALINE, Inj. ATROPINE given, ROSC attained. Patient was intubated and connected to mechanical ventilator. Poor prognosis explained to patient attendants. Patient attendants requested for discharge hence patient being discharged under LAMA.

ARH1.0001232878	**ARHIP56467**	Mrs. M UMA | Female | 40Yr 0Mth

RTA TRAUMATIC BRAIN INJURY
SMALL HAEMORRHAGIC CONTUSION LEFT BASIFRONTAL AND TEMPORAL LOBE
THIN ACUTE SDH ALONG RIGHT PARIETAL CONVEXITY
FRACTURE OCCIPITAL BONE, EXTENDING TO FORAMEN MAGNUM

Alleged h/o sustained injury due to RTA , 2 wheeler vs 4 wheeler on 03/07/2022 around 9.00 pm sustained injuries

H/o multiple episodes of vomiting+

AT ADMISSION:

Patient c/c/c

PR: 58/min

BP: 80/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft,

GCS- 15/15 Moving all 4 limbs equally

A 40 years old female patient UMA came with alleged h/o sustained injury due to RTA 2 wheeler vs 4 wheeler on 03/07/2022 around 9.00 pm sustained injuries, multiple episodes of vomitings+. All necessary investigations were done and diagnosed as RTA TRAUMATIC BRAIN INJURY, SMALL HAEMORRHAGIC CONTUSION LEFT BASIFRONTAL AND TEMPORAL LOBE, THIN ACUTE SDH ALONG RIGHT PARIETAL CONVEXITY, FRACTURE OCCIPITAL BONE, EXTENDING TO FORAMEN MAGNUM. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharged at request.

DISCHARGE MEDICATION:

1. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
2. TAB: VERTIN 24 MG ONCE DAILY AT 2PM FOR 7 DAYS.
3. TAB. DOLO 650 TWICE DAILY AT 8AM, 8PM FOR 5DAYS.
4. SOFT CERVICAL COLLOR

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD.

ARH1.0001029397	ARHIP56468	Mr. M. PRASAD | Male | 48Yr 9Mth 8Days

RTA POLYTRAUMA

BURST FRACTURE D3 VERTEBRAL BODY WITH MILD RETROPULSION

FRACTURE D4, D5 POSTERIOR ASPECTS OF VERTEBRAL BODIES

FRACTURE POSTERIOR ASPECT OF RIGHT 4th, 5th RIBS AT COSTOVERTEBRAL JUNCTION

Alleged h/o sustained injury due to RTA 2 wheeler vs 4 wheeler on 03/07/22 around 9.00 pm sustained injuries

AT ADMISSION:

Patient c/c/c

PR: 89/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

GCS- E4,V5,M6, Moving all 4 limbs equally

A 48 years old male patient PRASAD came with alleged h/o sustained injury due to RTA 2 wheeler vs 4 wheeler on 03/07/22 around 9.00 pm sustained injuries. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, BURST FRACTURE D3 VERTEBRAL BODY WITH MILD RETROPULSION, FRACTURE D4, D5 POSTERIOR ASPECTS OF VERTEBRAL BODIES, FRACTURE POSTERIOR ASPECT OF RIGHT 4th, 5th RIBS AT COSTOVERTEBRAL JUNCTION. Managed conservatively. Patient attendants requested for discharge to take higher center, hence patient is being discharged under LAMA.

ARH1.0001232593		**Name**	Mrs. MALLAVVA GADDAM
Patient Identifier	ARHIP56353	**Age**	61Yr 0Mth 9Days
Sex	Female	**Date of Admission**	26-Jun-2022
Date of Discharge			
MLC No			
Address	3-54/1 KONAPUR,Nizamabad,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY		

UNSTABLE ANGINA
MINOR CAD
VT/VF - DC CARDIOVERTED
PERSISTENT HYPOCALCAEMIA, HYPOMAGNESAEMIA FOR EVALUATION
NO H F
SR

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 83/min

BP: 130/90 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 61 years old female patient Mrs. MALLAVVA GADDAM presented with history of chest pain was diagnosed as NSTEMI and referred for further management. On evaluation patient had severe anaemia, persistent hyponatraemia, persistent hypokalaemia. She had an episode of VT/VF, successfully cardioverted. She was supplemented for hypokalemia, hypocalcemia, hyponatremia with TOLVAPTAN, IV KCL, IV Magnesium. She improved with medication. CAG done showed minor CAD. Her medications were optimised. She was discharged for further evaluation of suspected Siogrens with renal tubular acidosis with Nephrology and General Medicine as follow up.

DISCHARGE MEDICATION:

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1. TAB. SHELCAL-HD 1GM **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ALDACTONE 50MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MAGNORATE 1GM **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. LIVOGEN **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FOLVITE 5MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD / SOS

ARH1.0001232821	**Name**	Mr. ANJANEYULU G			
	Patient Identifier	ARHIP56447		**Age**	54Yr 5Mth 3Days
	Sex	Male		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	KMR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 7
	Primary Consultant	Dr. Vidya Sagar			

CORONARY ARTERY DISEASE, ACUTE IWMI

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 02/07/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR DONE ON 02/07/2022

C/o chest pain associated with SOB and profuse sweating since 1 day

S/P Hydrocele, hemorrhoidectomy 15 yrs back

AT ADMISSION:

Afebrile

PR: 69/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old male patient Mr. ANJANEYULU came with c/o chest pain associated with SOB and profuse sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 02/07/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 37 MM METAFOR [LOT NO: MG40, S/N :MTR35037] DONE ON 02/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. TONACT 80MG ONCE DAILY AT 8PM TO CONTINUE.

4) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232816	**Name**	Mr. RANAGAIAH SANAGARAM		
	Patient Identifier	ARHIP56446	**Age**	47Yr 0Mth 4Days
	Sex	Male	**Date of Admission**	01-Jul-2022
	Date of Discharge			
	MLC No			
	Address	6-42/1 SULTANABAD,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 1
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CARDIAC ARREST [CPR DONE : 10 DC SHOCKS GIVEN]

S/P CAG (01/07/222) -CAD-SVD [LMCA]

PRIMARY PTCA+DES TO LAD WITH 3.5 X 33 MM METAFOR DONE ON 01/07/2022
R/F: TOBACCO ADDICT, ALCOHOL, T2DM, HTN

C/o chest pain associated with SOB, sweating since 1 day

AT ADMISSION:

Afebrile

PR: 87/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 47 years old male patient Mr. RANAGAIAH SANAGARAM came with c/o chest pain associated with SOB, sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CARDIAC ARREST [CPR DONE : 10 DC SHOCKS GIVEN], S/P CAG (01/07/222) -CAD-SVD [LMCA], PRIMARY PTCA+DES TO LAD WITH 3.5 X 33 MM METAFOR DONE ON 01/07/2022. Patient planned for CAG and PTCA, patient develop to 5 episodes of VT before PTCA and was given DC shock 150 J 5 times. He also developed further 5 episodes of VT during the procedure and DC shock 150 J, 5 times given. Reverted to normal sinus rhythm. Patient was intubated during the procedure. Post PTCA was uneventful. Patient is being discharged in haemodynamically stable condition.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.

3) TAB. NOVOSTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.

4) INJ. INSULATARD 10 U S/C **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

5) TAB. PROLOMET R 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM TO CONTINUE.

7) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH RP-2, FBS & PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232952	**Name**	Mrs. GAJULA RAMADEVI		
	Patient Identifier	ARHIP56498	**Age**	48Yr 0Mth 0Days
	Sex	Female	**Date of Admission**	05-Jul-2022
	Date of Discharge			
	MLC No			
	Address	SRT-226, 2INC BASTHI, BELLAMPALLI,,Mancherial,Telangana	**Ward/ Bed No**	Ground Floor, Emergency Ward, Bed no:EME1
	Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

CORONARY ANGIOGRAM (05/07/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

K/C/O HYPOTHYROIDISM

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 48 years old female patient Mrs. GAJULA RAMADEVI came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, CORONARY ANGIOGRAM (05/07/2022) -NORMAL CORONARIES , PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. THYRONORM 50 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001232901		**Name**	Mr. CH BHOOMAIAH
Patient Identifier	ARHIP56475	**Age**	80Yr 0Mth 2Days
Sex	Male	**Date of Admission**	04-Jul-2022
Date of Discharge	04-Jul-2022		

MLC No			
Address	RENDLA GUDA JANNARAM MANCHERIYAL,Adilabad(Adilabad),Telangana	**Ward/Bed No**	First Floor, Day Care, Bed no:DC 3
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	**Consultants**	
Surgeons	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	**Anesthesiologists**	

⊟ Diagnosis

Diagnosis

Disease	Disease Type

CORONARY ARTERY DISEASE CHEST PAIN FOR EVALUATION,
CORONARY ANGIOGRAM DONE ON 4/07/2022,
PLAN:MEDICAL MANAGEMENT.

H/o chest pain 1 month back

Unstable angina

ECG showed -T wave biphasic

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 80 years old male patient BHOOMAIAH came with h/o chest pain 1 month back, ECG showed -T wave biphasic. Day Care angiogram done for risk stratification, CAG showed- Minor CAD, Plan medical management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. FLAVEDAN MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 3 MONTHS / SOS TO CARDIAC OPD

56490

ARH1.0001230547	**Name**	Mr. SATHIAIAH BURRA			
	Patient Identifier	ARHIP56490		**Age**	69Yr 2Mth 2Days
	Sex	Male		**Date of Admission**	05-Jul-2022
	Expired Date	06-Jul-2022			
	MLC No				
	Address	TANGALLAPALLY, KOHEDA,,Siddipet,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 9
	Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY)(NIMS),RENAL TRANSPLANT PHYSICIAN)--NEPHROLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

⊟ Diagnosis

Diagnosis

Disease	Disease Type
.	

SEPSIS WITH AKI
K/C/O CAD IWMI,CVA

C/o sudden SOB since 1 day

AT ADMISSION:

PR: 96/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 93% with Fio2

P/A: Soft

A 69 years old male patient Mr. SATHIAIAH BURRA came with c/o sudden SOB since 1 day. All necessary investigations were done and diagnosed as SEPSIS WITH AKI, K/C/O CAD IWMI,CVA. Poor prognosis explained to patient attendants, he may require mechanical ventilation. But patient attendants not willing for ventilator support. On 06/07/2022 at 1.40 AM patient developed bradycardia, CPR started according to ACLS guidelines, Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.47 AM on 06/07/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH AKI, K/C/O CAD IWMI,CVA.

56494

ARH1.0001232940		**Name**	Mr. SRINIVAS POODARI
Patient Identifier	ARHIP56494	**Age**	54Yr 0Mth 1Days
Sex	Male	**Date of Admission**	05-Jul-2022
Date of Discharge			
MLC No			
Address	Other,Other	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
Primary Consultant	DR. SANJAY KUMAR KAMINWAR		

CVA WITH ACUTE PONS BLEED

C/o weakness of left upper limb and lower limb
H/o loss of speech on deviation of mouth to right side

AT ADMISSION:

PR: 116/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100% on room air

P/A: Soft

A 54 years old male patient Mr. P SRINIVAS came with c/o weakness of left upper limb and lower limb, h/o loss of speech on deviation of mouth to right side. All necessary investigations were done and diagnosed as CVA WITH ACUTE PONS BLEED.

Managed conservatively. Poor prognosis explained to patient attendants, On 06/07/2022 at 12.10 PM patient developed bradycardia, CPR started according to ACLS guidelines, Patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.27 PM on 06/07/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CVA WITH ACUTE PONS BLEED

ARH1.0001232919		**Name**	Mrs. B SHANTHA		
	Patient Identifier	ARHIP56472		**Age**	50Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	04-Jul-2022
	Date of Discharge				
	MLC No				
	Address	Sulthanabad,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 7
	Primary Consultant	DR. SRI KARAN UDDESH			

NSIP [NON-SPECIFIC INTERSTITIAL PNEUMONIA]

C/o Shortness of breath, cough since 15 days

AT ADMISSION:

Patient c/c

PR: 120/min

BP: 100/60 mmHg

RS: Bilateral diffuse Velcro crackles, Tachypnoeic

CVS: S1S2

RR: 30/min

SPO2: 92% with 10 Litr of O2 NRBS

P/A: Soft

A 50 years old female patient Mrs. B SHANTHA came with above mentioned complaints. Patient was tachypnoeic in ER was put on NRBM mask at 10 L/min was maintaining saturation at 92%. CT chest revealed non-specific interstitial pneumonia involving bilateral lungs to about 70%-80%. Patient was started on glucocorticoids and broad spectrum antibiotics. Patient developed severe respiratory distress and patient was intubated in view of severe respiratory distress. Now the patient is on mechanical ventilator and needs further treatment, but the attenders are unwilling, hence patient is being discharged against medical advice.

ARH1.0001232944		**Name**	Mr. N BHADRAIAH		
	Patient Identifier	ARHIP56493		**Age**	65Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	05-Jul-2022
	Date of Discharge				
	MLC No				
	Address	CHINTAKUNTA,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 5
	Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal			

ACUTE EXACERBATION OF COPD
COR-PULMONALE

C/o shortness of breath grade 4 since 7 days associated with fever, cough with sputum

AT ADMISSION:

PR: 91/min

BP: 140/110 mmHg

RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 95% on room air

P/A: Soft

A 65 years old male patient BHADRAIAH came with c/o shortness of breath grade 4 since 7 days associated with fever, cough with sputum. All necessary investigations were done and diagnosed as ACUTE EXACERBATION OF COPD, COR-PULMONALE. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:
---

1) TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

4) TAB. BILAHENZ-M ONCE DAILY AT 8PM FOR 10 DAYS

5) TAB. PIDOTIMMUNE 800 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

6) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232809		**Name**	Ms. T KANAKALAXMI		
	Patient Identifier	ARHIP56440		**Age**	74Yr 0Mth 6Days
	Sex	Female		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	ADARSH NAGAR KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 2
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL			

ACUTE HEART FAILURE
TO RULE OUT OSA

Shortness of breath since 1 week aggravated since 1 day

Known case of severe MI stenosis, diabetic mellitus, hypertension, osteoarthritis, cervical spondylosis

AT ADMISSION:

Afebrile

PR: 84/min

BP: 130/80mmHg

RS: b/l wheeze+

CVS: S1S2

RR: 24/min

SPO2: 96% wirh 2 Litr O2

P/A: Soft

A 74 years old female patient KANAKALAXMI came with above mentioned complaints. Patient was diagnosed with heart failure, patient was treated with diuretics and patient also had probable OSA component. Patient was treated with nebulisation and INJ. HYDROCORT. In view of hypercapnic respiratory failure. The patient was treated with INJ. CEFTAZIDIME TAZOBACTAM for suspected community acquired pneumonia. Now the patient is symptomatically better hence being discharged with following advice.

DISCHARGE MEDICATION:
---

1. TAB. DYTOR 10 MG 1 TAB AT 8AM & ½ TAB AT 2 PM FOR 7 DAYS
2. TAB. PAN 40 MG ONCE IN A DAY AT 7 AM BEFORE BREAKFAST FOR 7 DAYS
3. INJ. HUMAN ACTRAPID 15 UNITS AT 8 AM BEFORE BREAKFAST , 15 UNITS AT 2 PM BEFORE LUNCH AND 15 UNITS AT 8 PM BEFORE DINNER TO CONTINUE
4. INJ. LANTUS 15 UNITS AT 10 PM AFTER DINNER TO CONTINUE
5. TAB. PREGABALIN 75 MG ONCE IN A DAY TO 8 PM FOR 7 DAYS
6. SYP. ASCORIL-D 10ML THRICE DAILY

REVIEW AFTER 1 WEEK WITH FBS, PLBS REPORTS IN GENERAL MEDICINE OPD
CPAP AT NIGHT FOR 4 HOURS

ARH1.0001229437		**Name**	Mr. LAXMAN BHAI RAJANBHAI RAO
Patient Identifier	ARHIP56407	**Age**	65Yr 10Mth 11Days
Sex	Male	**Date of Admission**	29-Jun-2022
Date of Discharge			
MLC No			
Address	B/H, RAJASTHAN COLONY, KARODIA BAJWA ROAD, ,Vadodara,Gujarat	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 6
Primary Consultant	DR. SRI KARAN UDDESH		

ACUTE CVA WITH SEPTIC SHOCK
AKI

H/o persistant giddiness
H/o multiple episodes of vomitings

Known case of type II diabetic mellitus

AT ADMISSION:

Afebrile

PR: 74/min

BP: 170/90mmHg

RS: b/l air entry+

CVS: S1S2

RR: 20/min

SPO2: 99% on room air

P/A: Soft

A 65 years old male patient Mr. LAXMAN BHAI RAJANBHAI RAO came with above mentioned complaints, initially patient had vomiting and giddiness so an MRI brain was ordered, MRI brain revealed bilateral mastoiditis, so an ENT consultation was taken ENT opined that it was CSOM with mastoiditis. So patient wanly on the third day of hospitalisation patient developed severe ataxia altered sensorium and difficulty in swallowing, a repeat MRI brain revealed Acute infarcts in right MCA territory, right corona radiata and centrum semiovale. Neurologist consultation was taken and his advice was followed. Throughout the course of hospitalisation the patient's clinical status deteriorated. Now the patient is on mechanical ventilator, needs further treatment, But the attendants are unwilling, hence patient is being discharged against medical advice.

ARH1.0001169766		**Name**	Mr. P J PRABHAKAR		
	Patient Identifier	ARHIP56491		**Age**	89Yr 5Mth 25Days
	Sex	Male		**Date of Admission**	05-Jul-2022
	Date of Discharge				
	MLC No				
	Address	SITARAMPUR BANK COLONY KARIMNAGAR,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

R/F : HTN, T2DM, BRONCHIAL ASTHMA

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 12 AM on 04/07/2022

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96% on room air

P/A: Soft

A 89 years old male patient PRABHAKAR came with c/o retrosternal chest pain since 12 AM on 04/07/2022. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]. Patient was advised for angiogram but in view of age and improvement by medication family members accepted for medical management. Patient was improved with antiplatelets, antianginal, antihypertensive medication. By the advice of the family members patient was discharged with medical management.

DISCHARGE MEDICATION:

---

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. LN BLOC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. NATRILIX-SR 1.5MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CONCOR COR 1.25 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. GLYCORYL M1 ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. DYNAPRES 0.2 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. SOBINIX 500 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

Patient Identifier	ARHIP56327	**Age**	20Yr 0Mth 14Days
Sex	Male	**Date of Admission**	24-Jun-2022
Date of Discharge	25-Jun-2022		
MLC No			
Address	RAMNAGAR MANCHRIAL ,Nirmal,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 3
Primary Consultant	DR. SUBRAT KUMAR SOREN --NEUROSURGERY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
ROAD TRAFFIC ACCIDENT WITH HEAD INJURY MINIMAL PNEUMOCEPHALUS FRONTAL LOBE CONTUSION.	

Alleged to have sustained injury due to RTA 2 wheeler vs 4 wheeler on 24/06/22 sustained injuries

AT ADMISSION:

Patient drowsy

Febrile -100 F

PR: 83/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft, BS+

GCS- E2,V3,M5, B/l PERL

A 59 years old female patient LAXMI REDDY came with Alleged to have sustained injury due to RTA Rolling of Car over the road on 26/05/22 around 3.30 pm sustained injury to right arm. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, MULTIPLE SMALL HAEMORRHAGIC CONTUSIONS, TRAUMATIC SAH, DIFFUSE AXONAL INJURY GRADE-I, FRACTURE RIGHT HUMERUS. Patient was hypotensive, ionotropic support given and now patient is haemodynamically stable. Patient's Hb was 7.7 mg/dl and 1 unit PRBC transfusion given. Patient's condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.0001232446		**Name**	Mr. M RAJANNA		
Patient Identifier	ARHIP56397		**Age**	58Yr 0Mth 15Days	
Sex	Male		**Date of Admission**	29-Jun-2022	
Date of Discharge					
MLC No					
Address	MALLIAL JAGITAL ,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 4	
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY				

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P IWMI, CVA

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE ON 02/07/2022.

C/o retrosternal chest pain a/w sweating since 1 day

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 58 years old male patient Mr. RAJANNA presented to hospital with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P IWMI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO OM, PDA] DONE ON 02/07/2022. Post operative period was uneventful. Neurophysician consolidation taken in view of CVA, acute infarcts and advice followed. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, NO PE/CLOT/VEG, EF-50%

BMI is _____ kg/m2.

Sr. Creatinine report on 03.07.2022 1.3 mg/dl.

DISCHARGE MEDICATION:

---

1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. PROLOMET XL 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

6) TAB. MET XL 12.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

7) TAB. STROCIT 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

8) TAB. ENCORATE 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

10) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

11) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001232934		**Name**	Mr. LAXMIRAJAM SANDAVENI
Patient Identifier	ARHIP56492	**Age**	50Yr 0Mth 3Days
Sex	Male	**Date of Admission**	05-Jul-2022
Date of Discharge			
MLC No			
Address	KARIMNAGAR,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Male General Ward, Bed no:GW 13
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

R/F: HTN, DM

CORONARY ANGIOGRAM DONE ON 05/07/2022 – CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA CC DONE ON 05/07/2022

C/o sudden retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 100/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 50years old male patient Mr. LAXMIRAJAM SANDAVENI came with c/o sudden retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F: HTN, DM, CORONARY ANGIOGRAM DONE ON 05/07/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 18 MM PRONOVA CC DONE ON 05/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

---

1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

6) TAB. INJ. HUMAN MIXTARD 30/70 24 UNITS AT 8AM AND 12 UNITS AT 8PM TO CONTINUE.

7) CAP. METOLAR XR 25MG **ONCE IN A DAY AT 8 AM** TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232756		**Name**	Mrs. MANNEMMA MOLAKULA		
	Patient Identifier	ARHIP56423		**Age**	49Yr 5Mth 8Days
	Sex	Female		**Date of Admission**	30-Jun-2022
	Date of Discharge				
	MLC No				
	Address	8-44, CHINNAKODUR,Siddipet,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 2
	Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY			

RIGHT RENAL CALCULUS
SURGERY: RIGHT PCNL+DJ STENTING DONE ON 04.07.2022

C/o Right loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 49 yrs old female patient Mrs. MANNEMMA MOLAKULA came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PCNL+DJ STENTING DONE ON 04.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

---

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001233003		**Name**	Mr. K VENKAT NARSAIAH
Patient Identifier	ARHIP56505	**Age**	83Yr 0Mth 2Days
Sex	Male	**Date of Admission**	06-Jul-2022
Date of Discharge			
MLC No			
Address	NEELOZIPALLI BOINPALLI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 3
Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		

ACUTE HEART FAILURE
D5 WEDGE COMPRESSION FRACTURE

C/o low backache, facial puffiness and shortness of breath

Known case of bronchial asthma

AT ADMISSION:

Afebrile

PR: 87/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 93% on 2 L of O2

P/A: Soft,

A 83 years old male patient Mr. K VENKAT NARSAIAH came with above mentioned. Patient was diagnosed to have acute heart failure and was treated with IV diuretics. 2D echo was done and Cardiologist consultation was taken. In view of low back pain MRI spine was done which revealed D5 wedge compression fracture, neurosurgeon opinion was taken and neurosurgeon advised conservative management. Now the patient is requires 1 Litr/min oxygen support and has hence been advised further hospital stay, but the attenders are unwilling, hence he is being discharged against medical advice.

ARH1.0001232928		**Name**	Mr. SRINIVAS BABU N
Patient Identifier	ARHIP56477	**Age**	51Yr 0Mth 4Days
Sex	Male	**Date of Admission**	04-Jul-2022
Date of Discharge			
MLC No			
Address	HUSNABAD,Husnabad,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:101 B
Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY		

CKD STAGE-V

MVP WITH SEVERE MR [ECCENTRIC JET], MILD PAH

NORMAL LV FUNCTION, RVSP-30 mmHg

HTN, DM

C/o Shortness of breath associated with b/l pedal edema

Known case of HTN, T2DM, CKD

AT ADMISSION:

PR: 112/min

BP: 170/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 51 years old male patient Mr. SRINIVAS BABU N came with c/o shortness of breath associated with b/l pedal edema . All necessary investigations were done and diagnosed as CKD STAGE-V, MVP WITH SEVERE MR [ECCENTRIC JET], MILD PAH, NORMAL LV FUNCTION, RVSP-30 mmHg, HTN, DM. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise. 3 cycles of dialysis completed.

DISCHARGE MEDICATION:

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1. TAB. FAROALFA 200 MG **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. DYROR 20 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CILACAR M 10/50 **ONCE IN A DAY AT 2 PM**TO CONTINUE.
5. TAB. GEROZ –LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
6. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. THYRONORM 25 MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
8. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. CARNIK-LC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001232805		**Name**	Mr. DEVAIAH M
Patient Identifier	ARHIP56483	**Age**	72Yr 9Mth 7Days
Sex	Male	**Date of Admission**	04-Jul-2022
Date of Discharge			
MLC No			

Address	6-6-1064,SHIVAJI NAGAR,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:106 A
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56483	ARH1.000123280

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
HERNIA (INGUINAL) WITH MESH				

RIGHT INGUINAL INDIRECT HERNIA
SURGERY: RIGHT INGUINAL HERNIOPLASTY DONE ON 06/07/2022

C/o swelling in right inguinal region since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-86/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 72 yrs old male patient Mr. DEVAIAH came with c/o swelling in right inguinal region since 1 month. All necessary investigations done and diagnosed as RIGHT INGUINAL INDIRECT HERNIA, SURGERY: RIGHT INGUINAL HERNIOPLASTY DONE ON 06/07/2022. Findings: 2 cm above inguinal ligament, Indirect defect noted. Post

operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. GLUTAVAULT SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
5. TAB: STAMLO 5 MG ONCE DAILY AT 8AM FOR 10 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.0001231527		**Name**	Mr. SUDHEER KALLEPALLY		
	Patient Identifier	ARHIP56454		**Age**	40Yr 1Mth 8Days
	Sex	Male		**Date of Admission**	02-Jul-2022
	Date of Discharge	04-Jul-2022			
	MLC No				
	Address	1-84,paddapalli,karimnagr,Karimnagar,Telangana		**Ward/Bed No**	Second Floor, Semi Private, Bed no:118 C
	Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY)(NIMS),RENAL TRANSPLANT PHYSICIAN)--NEPHROLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

ACUTE ON CHRONIC KIDNEY DISEASE –DN
RENAL ANEMIA
DIABETES MELLITUS
HYPERTENSION

C/o facial puffiness, fever and cough since 3 days

Known case of HTN, T2DM

AT ADMISSION:

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 40 years old male patient Mr. SUDHEER KALLEPALLY came with c/o facial puffiness, fever and cough since 3 days . All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE –DN
RENAL ANEMIA, DIABETES MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. SOBINIX DS **TWICE IN A DAY AT 8 AM 8 PM**TO CONTINUE.
2. TAB. CARDIVAS 12.5 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MOXIVAS 3.5 MG THRICE DAILY AT 8AM, 2PM & 8PM TO CONTINUE.
4. TAB. GEROZ –LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
5. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 5 DAYS
6. TAB. DYTOR 20 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. METOZ 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. CALCI-CZ **ONCE IN A DAY AT 2 PM**TO CONTINUE.
9. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
10. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001233014		**Name**	Mr. RAJESWAR RAO ALLADI		
	Patient Identifier	ARHIP56506		**Age**	75Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	06-Jul-2022
	Date of Discharge				
	MLC No				
	Address	SHAKALLA, BUGGARAM, JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 10
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE			

SEPSIS WITH MODS

? TOXIC MEGACOLON

C/o shortness of breath since 2 days
Vomitings and loose since 3 days

Known case of hypertension,
Known case of pulmonary TB 6 years back recovered

AT ADMISSION:

Afebrile

PR: 129/min

BP: 110/70mmHg

RS: b/l air entry+, crepts+

CVS: S1S2

RR: 30/min

SPO2: 98% on 6 Litr of O2

P/A: Soft

A 75 years old male patient Mr. RAJESWAR RAO ALLADI came with above mentioned complaints, patient's saturation was low, started on oxygen support, patient was started on broad spectrum antibiotics with INJ. MEROPENEM and INJ. TEICOPLANIN according to creatinine clearance patient had acute kidney injury with oliguria, so nephrology consultation was taken and SLED was initiated. As patient had abdominal tenderness an ultrasound abdomen was done revealed ? paralytic ileus hence a CT abdomen was done revealed.
Colitis involving rectum and proximal sigmoid colon with grossly distended sigmoid colon ---? Toxic Megacolon. General Surgeon consultation was taken and attenders were explained about the need for surgery but the attenders are unwilling hence patient is being discharged against medical advice.

ARH1.000123272727	**Name**	Mr. MACHA SRINIVAS	
Patient Identifier	ARHIP56399	**Age**	45Yr 0Mth 9Days
Sex	Male	**Date of Admission**	29-Jun-2022
Date of Discharge			
MLC No			
Address	utoor,manakondur,Karimnagar,Telangana	**Ward/Bed No**	First Floor, SICU, Bed no:SICU 7
Primary Consultant	DR. SRI KARAN UDDESH -- INTERNAL MEDICINE	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56399	ARH1.000123272

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LAPAROTOMY PLUS SMALL BOWEL RESECTION AND ANASTOMOSIS				

SEPSIS WITH MODS

ACUTE INTESTINAL OBSTRUCTION SECONDARY TO CA. SIGMOID COLON.
SURGERY - EXPLORATIVE LAPAROTOMY + TRANSVERSE END COLOSTOMY + RESCENDING AND SIGMOID COLECTOMY WITH HARTMAN'S PROCEDURE DONE ON 20/6/2022.

SMALL BOWEL PERFORATION

SMALL BOWEL RESECTION AND ANASTOMOSIS

C/o pain abdomen
Mild shortness of breath
Productive cough

AT ADMISSION:

Febrile-101 F

PR: 92/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95% on room air

P/A: Soft

A 45 years old male patient Mr. MACHA SRINIVAS came with above mentioned complaints, patient had undergone a colostomy, as the patient had acute intestinal obstruction secondary to suspected cancer of the sigmoid colon. Patient had sepsis with multiorgan dysfunction patient was started on broad spectrum antibiotics IV fluids and nebulization. Patient improved over the next 3 days of hospitalization. Patient developed faecal fistula with bleeding from abdominal wound site. General Surgeon consultation was taken on evaluation it showed small bowel perforation, patient underwent small bowel resection + jejunojejunal anastomosis + ileo-ileal anastomosis. The patient was on mechanical ventilator, patient was requiring ionotropic support, post surgery patient was again started on INJ. MEROPENEM and INJ. LINEZOLID patient was weaned off mechanical ventilation ionotropic support, now the

patient is requiring 2 Ltrs of oxygen/min and he is clinically better. He needs further treatment but the attenders are unwilling so the patient is being discharged at request.

ARH1.0001232932		**Name**	Mr. VENKATASWAMY MADISHETTI
Patient Identifier	ARHIP56489	**Age**	64Yr 0Mth 4Days
Sex	Male	**Date of Admission**	04-Jul-2022
Date of Discharge			
MLC No			
Address	209 KAPU WADA,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A		

CORONARY ARTERY DISEASE, ACUTE IWMI

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, SR

CORONARY ANGIOGRAM DONE ON 05/07/2022 – CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO LAD WITH METAFOR 3.5 X 32 MM, RCA WITH METAFOR 3.0 X 48 MM DONE ON 05/07/2022
R/F: HTN

C/o sudden left sided chest pain a/w multiple episodes of vomitings

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 64 years old male patient Mr. VENKATASWAMY MADISHETTI came with c/o sudden left sided chest pain a/w multiple episodes of vomitings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, SR, CORONARY ANGIOGRAM DONE ON 05/07/2022 – CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO LAD WITH METAFOR 3.5 X 32 MM, RCA WITH METAFOR 3.0 X 48 MM DONE ON 05/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. LNBLOC 10 MG ONCE DAILY AT 8AM TO CONTINUE.

6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101'F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001232937		**Name**	Mr. YAMSANI GANGADHAR
Patient Identifier	ARHIP56495	**Age**	69Yr 0Mth 3Days
Sex	Male	**Date of Admission**	05-Jul-2022
Date of Discharge			
MLC No			
Address	PURANIPET JAGITAL ,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--		

CORONARY ARTERY DISEASE , ACUTE AWMI

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

MODERATE MR, SR

S/P CORONARY ANGIOGRAM DONE ON 06/07/2022 – CAD-TVD [LAD, RAMUS, RCA]

PLAN MEDICAL MANAGEMENT.

R/F: HTN, T2DM

C/o shortness of breath on exertion and fever since 3-4 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 69 years old male patient Mr. YAMSANI GANGADHAR came with c/o shortness of breath on exertion and fever since 3-4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWMI. Patient was treated with antiplatelets, antianginal, antihypertensive and anticoagulant medication. Coronary angiogram was done on 03/07/22 showing CAD -TVD [LAD, RAMUS, RCA] advised CABG. In view of CAD-TVD+ severe LV dysfunction, moderate MR, Age risk and poor prognosis involved in surgery CABG referred by CT Surgeon and advised medical management. Patient is being discharged in haemodynamically stable condition with medical management advice

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. INJ HUMAN INSULATARD S/C 8 Units AT 8AM AND 8PM CONTINUE
6. TAB. RECLIDE MR 30 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. DYTOR PLUS 10 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001041546		**Name**	Mr. POSAIAH BERA	~~~~~~ ~	
	Patient Identifier	ARHIP56497		**Age**	79Yr 1Mth 6Days
	Sex	Male		**Date of Admission**	05-Jul-2022
	Date of Discharge				
	MLC No				
	Address	3-5/5 BUDHAKHUD BELLAMPALLI,Adilabad(Adilabad),Andhra Pradesh		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 11
	Primary Consultant	Dr Chandra Shekar Sathineni			

UPPER GI BLEED
APD

C/o blood vomitings 2-3 episodes, bilateral pedal oedema

Known case of hypertension, diabetic mellitus
S/P AVR in 2006

AT ADMISSION:

Afebrile

PR: 70/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 79 years old male patient Mr. POSAIAH BERA came with c/o blood vomitings 2-3 episodes, bilateral pedal oedema.
Known case of hypertension, diabetic mellitus, S/P AVR in 2006. All necessary investigations were done and diagnosed as UPPER GI BLEED, APD. Managed conservatively. 4 units PCV, 4 units FFP transfusions done. Endoscopy done showed small antral ulcer, no active UGI bleed.

Cardiologist consultation taken and advice followed. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

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1. TAB. PANTOCID-L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
2. TAB. GEROZ-LP ONCE DAILY AT 2PM FOR 15 DAYS
3. TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS
4. TAB. ACITROM 2 MG ONCE DAILY AT 4PM TO CONTINUE
5. TAB. DAPARYL 10 MG ONCE DAILY AT 2PM FOR 15 DAYS
6. TAB. LANOXIN 0.25 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE 5/7
7. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
8. TAB. CARDACE 1.25 MG ONCE DAILY AT 8AM TO CONTINUE
9. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE
10. TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

REVIEW AFTER 7 DAYS IN CARDIOLOGY OPD WITH PT/INR REPORT

ARH1.0001232795	**Name**	Ms. BHVATHI VIJAYALAKSHI			
	Patient Identifier	ARHIP56434		**Age**	52Yr 0Mth 8Days
	Sex	Female		**Date of Admission**	01-Jul-2022
	Date of Discharge				
	MLC No				
	Address	16-9-68, RAMAGUNDAM,PEDDAPALLI,Telangana		**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 5
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY			

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION+DM+HTN+ S/P IWMI, IW [SCAR]

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] DONE ON 05/07/2022.

C/o retrosternal chest pain a/w sweating since 3 days

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 52 years old female patient BHVATHI VIJAYALAKSHI presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION+DM+HTN+ S/P IWMI, IW [SCAR], SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] DONE ON 05/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, SEVERE LV DYSFUNCTION, NO PE/CLOT/VEG, EF-30%

BMI is 26.4 kg/m2.

Sr. Creatinine report on 05.07.2022 0.9 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

5) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM TO CONTINUE.

9) TO CONTINUE DIABETIC OWN MEDICATION.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001230922		**Name**	Mr. BANDI PARSHURAM .		
	Patient Identifier	ARHIP56480		**Age**	40Yr 1Mth 24Days
	Sex	Male		**Date of Admission**	04-Jul-2022
	Date of Discharge				
	MLC No				
	Address	MADDIKUNTA, MANAKONDUR,,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:116 B
	Primary Consultant	Dr. SURESH GOUD S(			

RIGHT PROXIMAL URETERIC CALCULUS
SURGERY : RIGHT PUSH BACK PCNL AND DJ STENTING DONE ON 05.07.2022

C/o right loin pain, burning micturition since 5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 40 yrs old male patient Mr. BANDI PARSHURAM came to the hospital with c/o right loin pain, burning micturition since 5 days. All necessary investigations done and diagnosed as RIGHT PROXIMAL URETERIC CALCULUS, SURGERY : RIGHT PUSH BACK PCNL AND DJ STENTING DONE ON 05.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

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1. TAB: CEFRON 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z -NS ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001232858		**Name**	Mr. CHAWLA MANOHAR
Patient Identifier	ARHIP56455	**Age**	62Yr 1Mth 26Days
Sex	Male	**Date of Admission**	02-Jul-2022
Date of Discharge			
MLC No			
Address	3-3-99, PATEL ROAD, KORATLA,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:117 B
Primary Consultant	Dr. Iftekarali (MS (Orthopaedics),Consultant	**Consultants**	

	Orthopaedic Surgeon)--ORTHOPAEDICS		
Surgeons	Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56455	ARH1.000123285

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
ORIF DISTAL TIBIA LOCKING PLATE LT				

CLOSED COMMUNITTED FRACTURE DISTAL TIBIA LEFT

SURGERY: ORIF WITH DISTAL TIBIA LOCKING PLATE LEFT DONE ON 05/07/2022

Alleged to have sustained injury due to slip and fall at home, sustained injury to left leg

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-82/min
BP-140/90mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 62 years old male patient Mr. CHAWLA MANOHAR came with alleged to have sustained injury due to slip and fall at home, sustained injury to left leg. All necessary investigations were done and diagnosed as CLOSED COMMUNITTED FRACTURE DISTAL TIBIA LEFT, SURGERY: ORIF WITH DISTAL TIBIA LOCKING PLATE LEFT DONE ON 05/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:
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1. TAB. TROUFIZ 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. VOVERAN SR TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. KYLID-RD   ONCE DAILY AT 8AM FOR 10 DAYS.
4. TAB. OSTOCAL ONCE DAILY AT 2PM FOR 10 DAYS.
5. TAB. DISENCHAR TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO DR. IFTEKARALI SIR OPD.

ARH1.0001143768		**Name**	Mr. VODNALA SATHAIAH
Patient Identifier	ARHIP56496	**Age**	56Yr 0Mth 4Days
Sex	Male	**Date of Admission**	05-Jul-2022
Date of Discharge			
MLC No			
Address	3-146,MUJAMPALY,MANKONDOOR,,Karimnagar,Telangana	**Ward/ Bed No**	Second Floor, Semi Private, Bed no:119 B
Primary Consultant	Dr. SUMALATHA V--PULMONOLOGY		

COPD WITH COR PULMONALE

C/o shortness of breath associated with cough and sputum

AT ADMISSION:

Afebrile

PR: 96/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98% with room air

P/A: Soft

A 56 years old male patient Mr. VODNALA SATHAIAH came with c/o shortness of breath associated with cough and sputum. All necessary investigations were done and diagnosed as COPD WITH COR PULMONALE. Managed conservatively. Psychiatric consultation taken and advice followed. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharge at request.

DISCHARGE MEDICATION:

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1. NEBULISATION WITH DUOLIN 6th hrly FOR 5 DAYS
   NEBULISATION WITH BUDECORT 0.5 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
   NEBULISATION WITH GLYCOHEAL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS THEN
2. GLYCOHALE-FB TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS AND STOP
3. LUPIHALER
4. TAB. PAH 20MG ONCE DAILY AT 8 AM FOR 10 DAYS.
5. TAB. IVEPRED 4 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS THEN
6. TAB. IVEPRED 4 MG ONCE DAILY AT 8AM FOR 5 DAYS THEN STOP
7. TAB. CLAVUM 625 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
8. TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
9. TAB. ABIPHYLLINE 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
10. SYP. ASCORYL-LS 10 ml THRICE DAILY AT 8AM, 2PM AND 8PM
11. TAB. MUCINAC 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN PULMONOLOGIST OPD

ARH1.0001222877	**Name**	Mr. K LAXMINARAYANA			
	Patient Identifier	ARHIP56532		**Age**	62Yr 8Mth 21Days
	Sex	Male		**Date of Admission**	08-Jul-2022
	Date of Discharge				
	MLC No				
	Address	KOTHUR, DHARMARAM,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:105 B
	Primary Consultant	Dr Chandra Shekar Sathineni			

ACUTE GASTROENTERITIS
DYSELECTROLYTAEMIA

C/o abdomen pain on and off (lower abdominal region) since 1 day

Known case of hypertension on medication

AT ADMISSION:

Afebrile

PR: 100/min

BP: 110/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. K LAXMINARAYANA came with c/o abdomen pain on and off (lower abdominal region) since 1 day. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, DYSELECTROLYTAEMIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1) TAB. RAZO-D ONCE DAILY AT 8AM FOR 10 DAYS

2) TAB. HEADNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001232912	**Name**	Mr. U VEERAIAH			
	Patient Identifier	ARHIP56500		**Age**	36Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	05-Jul-2022
	Date of Discharge				
	MLC No				
	Address	RAMAKRISHNA PUR MANDAMARRI MANCHERIYAL,Adilabad(Adilabad),Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:123 C
	Primary Consultant	DR. SUBRAT KUMAR SOREN			

L4-L5 LUMBAR CANAL STENOSIS
SURGERY: L4 LAMINECTOMY & MICRODISCECTOMY DONE ON 06/07/22

C/o low backache since 3 years,
Pain intensity increased since 3 months
Tingling and numbness of lower limbs

PHYSICAL EXAMINATION:

ON ADMISSION
---
afebrile
PR-82/min
BP-130/90mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 36 years old male patient Mr. U VEERAIAH came with c/o low backache since 3 years, pain intensity increased since 3 months, tingling and numbness of lower limbs. All necessary investigations were done and diagnosed as L4-L5 LUMBAR CANAL STENOSIS, SURGERY: L4 LAMINECTOMY & MICRODISCECTOMY DONE ON 06/07/22. Findings: Tight dural sac, disc protrusion. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB. AUGMENTIN 625 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
2. TAB. GABANTIP AT 100/10 ONCE DAILY AT 8PM FOR 10 DAYS.
3. TAB. TOLIRITAS-D TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
4. TAB. ND-Q10 ONCE DAILY AT 2PM FOR 10 DAYS.
5. TAB. ND-K2 ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD

ARH1.0001226279		**Name**	Mr. A.V. RAMANA REDDY
Patient Identifier	ARHIP56521	**Age**	69Yr 9Mth 3Days
Sex	Male	**Date of Admission**	07-Jul-2022
Date of Discharge			
MLC No			
Address	7-3-160 : DHARMAPURI ROAD JAGTIAL 9440036031,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:116 A
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56521	ARH1.000122627

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
RIGHT HERNIA (INGUINAL) WITH MESH				

RIGHT INGUINAL INDIRECT HERNIA

SURGERY : OPEN RIGHT INGUINAL HERNIOPLASTY DONE ON 08.07.2022

C/o swelling in right inguinal region

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 69 yr old male patient Mr. A.V. RAMANA REDDY came with c/o swelling in right inguinal region. All necessary investigations done and diagnosed as RIGHT INGUINAL INDIRECT HERNIA, SURGERY : OPEN RIGHT INGUINAL HERNIOPLASTY DONE ON 08.07.2022. Findings: Long studing indirect sac noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.

2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 15 DAYS.
5. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM

Review after 10 days in General Surgery OPD.

ARH1.0001232670		**Name**	Mr. HANMANDLU KONDURI		
	Patient Identifier	ARHIP56386		**Age**	60Yr 0Mth 11Days
	Sex	Male		**Date of Admission**	28-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KODIMIAL, JAGITIAL,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:105 A
	Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL			

UPPER GI BLEED
SEPSIS WITH MODS
AO CKD

C/o unresponsiveness state
Decreased food intake since few days

Known case of hypertension, diabetes mellitus
S/P CABG

AT ADMISSION:

Febrile, not responding to commands

PR: 74/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 95% on room air

P/A: Soft

A 60 years old male Mr. HANMANDLU KONDURI came with above mentioned complaints. On examination the patient's capillary blood glucose levels were low so patient was treated with 25% DEXTROSE. Patient was diagnosed as neuroglycopenia and sepsis secondary to probable UTI . Patient was started on broad spectrum antibiotics, the patient had AKI which was non-oliguric. RFT was monitored along with electrolytes. Blood culture and urine culture sent, both was sterile. The patient's clinical condition improved over the course of hospitalization, nephrology opinion was taken and advice followed. A workup for CKD was done and the patient was diagnosed with acute onset chronic kidney disease. On 04/07/2022 morning patient had an episode of haematemesis. 2 units FFP, 3 units PRBC transfusion given. Patient was sent for UGI scopy it revealed multiple duodenal and linear ulcers in the antrum, patient was underwent sclerotherapy. After 24 hours of sclerotherapy the patient still had haematemesis, so gastroenterologist opinion was taken again and patient underwent APC. The patient requires Gastroenterology Care and he is being referred to a Gastroenterologist centre.

DISCHARGE MEDICATION:

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1. TAB. SEVLAMER 400 MG **THRICE IN A DAY AT 8 AM 2 PM 8 PM** FOR 7 DAYS
2. TAB. FEBUGET 40 MG **ONCE IN A DAY AT 2 PM** FOR 7 DAYS
3. TAB. SHELCAL-D **ONCE IN A DAY AT 2 PM** FOR 7 DAYS
4. TAB. DAPARYL 10 MG **ONCE IN A DAY AT 2 PM** FOR 7 DAYS
5. TAB. NODOSIS 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
6. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233080		**Name**	Mrs. RAYAMALLAMMA AMUULA		
	Patient Identifier	ARHIP56525		**Age**	63Yr 0Mth 2Days
	Sex	Female		**Date of Admission**	07-Jul-2022
	Date of Discharge				
	MLC No				
	Address	BELLAMPALLI,Adilabad(Adilabad),Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:120 A
	Primary Consultant	DR. SRI KARAN UDDESH --			

OBSTRUCTIVE SLEEP APNOEA
MORBID OBESITY
AO CKD
PROBABLE HEART FAILURE WITH PRESERVED EJECTION FRACTION

C/o bilateral pedal edema

AT ADMISSION:

Afebrile

PR: 84/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94% on room air

P/A: Soft

A 63 years old female Mrs. RAYAMALLAMMA AMUULA came with above mentioned complaints, patient was suspected to have obstructive sleep apnoea, so patient underwent polysomnography in which an apnoea hypopnoea index was 30, so now patient has been diagnosed with OSA and has been advised CPAP at night for 4 hours. Patient presented with bilateral pedal oedema and dyspnoea on exertion, so workup for ruling out kidney disease and heart failure was done. Renal profile revealed creatinine of 1.3 and a workup for CKD was done and patient was diagnosed to have CKD. 2D echo was normal. Now the patient is clinically better, hence being discharged with the following advice.

DISCHARGE MEDICATION:

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1. TAB. DYTOR PLUS 10/50 **ONCE IN A DAY AT 8 AM** FOR 1 MONTH
2. TAB. SHELCAL-D **ONCE IN A DAY AT 2 PM** FOR 1 MONTH
3. TAB. GABAPIN-NT **ONCE IN A DAY AT 8 PM** FOR 1 MONTH
4. SYP. LACTIFIBER 3 TSP ONCE IN A DAY AT 8 PM
5. CPAP AT NIGHT FOR 6 hrs

REVIEW AFTER 4 WEEKS IN GENERAL MEDICINE OPD WITH RP-II REPORTS

ARH1.0001232517		**Name**	Mrs. SINGADASARI BHAGYA LAXMI
Patient Identifier	ARHIP56460	**Age**	41Yr 0Mth 15Days
Sex	Female	**Date of Admission**	02-Jul-2022
Date of Discharge			
MLC No			
Address	SARVAREDDYPALLI,GANGADHARA,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Female General Ward, Bed no:GW 3
Primary Consultant	Dr. SURESH GOUD		

RIGHT STAGHORN CALCULUS
SURGERY: RIGHT ANATROPHIC PYELOLITHOTOMY DONE ON 05/07/2022

C/o right and left flank pain since 1 week.

ON ADMISSION

Patient c/c

Afebrile

PR-82/min

BP-100/60mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-99%

A 41 years old female patient Mrs. SINGADASARI BHAGYA LAXMI presented to hospital with c/o right and left flank pain since 1 week. All necessary investigations were done and diagnosed as RIGHT STAGHORN CALCULUS, SURGERY: ANATROPHIC PYELOLITHOTOMY RIGHT DONE ON 05/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

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1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

ARH1.0001233032		**Name**	Mr. RAJAIAH AKULA
Patient Identifier	ARHIP56513	**Age**	65Yr 2Mth 3Days
Sex	Male	**Date of Admission**	06-Jul-2022
Date of Discharge			
MLC No			
Address	2-123, MALLAPOOR,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 4
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology		

LEFT PROXIMAL URETERIC CALCULUS
PLAN : LEFT PUSH BACK PCNL AND DJ STENTING, SURGERY ABONDONED

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 65 yrs old male patient Mr. RAJAIAH AKULA came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT PROXIMAL URETERIC CALCULUS, patient plan for LEFT PUSH BACK PCNL AND DJ STENTING but surgery was abondened. Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

---

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10 DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS

ARH1.0001232336	**Name**	Mrs. B VANUSHA			
	Patient Identifier	ARHIP56415		**Age**	24Yr 0Mth 21Days
	Sex	Female		**Date of Admission**	30-Jun-2022
	Date of Discharge				
	MLC No				
	Address	KOLVAI BEERPUR JAGITIAL,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CT POST, Bed no:CT 2
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		**Consultants**	
	Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP56415	ARH1.000123233

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
VSD CLOSURE	06-Jul-2022 09:40:00			

SUB AORTIC VENTRICULAR SEPTAL DEFECT.

Surgery: VENTRICULAR SEPTAL DEFECT CLOSURE WITH DACRON PATCH DONE ON 06/07/2022.

c/o sub aortic VSD attempted device closures and admitted for VSD Closure.

ON ADMISSION

Pt c/c

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-100%

A 24 years old female patient Mrs. VANUSHA presented to hospital with c/o sub aortic VSD attempted device closures and admitted for VSD Closure. All necessary investigations were done and diagnosed as SUB AORTIC VENTRICULAR SEPTAL DEFECT, VENTRICULAR SEPTAL DEFECT CLOSURE WITH DACRON PATCH DONE ON 06/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advise.

POST VSD CLOSURE 2D ECHO REPORTS SHOWED MILD TR, NORMAL LV/RV FUNCTION, EF-60%.

DISCHARGE MEDICATION:

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1. TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
4. TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
5. TAB. CALPOL 500MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.
6. TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD.

ARH1.0001233125		**Name**	Mr. ANIL KUMAR
Patient Identifier	ARHIP56546	**Age**	32Yr 0Mth 2Days
Sex	Male	**Date of Admission**	09-Jul-2022
Date of Discharge	09-Jul-2022		
MLC No			
Address	Koheda,Karimnagar,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME1
Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

L3 BRUST FRACTURE WITH CAVDA EQUINA SYNDROME WITH PARAPERESIS

Alleged h/o RTA slipped and fall from bike on 09/07/2022 sustained back injury

AT ADMISSION:

Patient c/c/c

PR: 83/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft, BS+

GCS- E4,V5,M6

A 32 years old male patient Mr. ANIL KUMAR came with alleged h/o RTA slipped and fall from bike on 09/07/2022 sustained back injury. All necessary investigations were done and diagnosed as L3 BRUST FRACTURE WITH CAUDA EQUINA SYNDROME WITH PARAPERESIS. Patient was managed conservatively. Patient's condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.0001098189		**Name**	Mrs. MANCHALA VASANTHA		
	Patient Identifier	ARHIP56251		**Age**	40Yr 5Mth 14Days
	Sex	Female		**Date of Admission**	20-Jun-2022
	Date of Discharge	20-Jun-2022			
	MLC No				
	Address	MODELA,Adilabad(Adilabad),Telangana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 2
	Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. KRISHNA CHAITANYA M (MD,DM,(FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CAD OLD AWMI ,S/P PTCA TO LAD (2016)NAV,AOE FC3,NO HF ,SR.
CAG: LAD STENT PATENT,RCA MID 80% STENOSIS.
PLAN :PTCA TO RCA.

C/o pain in left hand,
History of dyspnoea
Known case of hypertension, CAD, S/P PTCA

AT ADMISSION:

Afebrile

PR: 91/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft,

A 40 years old female patient Mrs. MANCHALA VASANTHA known case of CAD S/P PCI to LAD (2016), newly diagnosed to have diabetes, now presented with complaints of angina FC-III. On evaluation, she underwent CAG. CAG showed patent LAD stent and mid RCA has 80% stenosis. She was advised PTCA to RCA and control of diabetes. She was discharged for PTCA as early as possible .

DISCHARGE MEDICATION:

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1. TAB. AXCER 180 MG F/B 90 MG **TWICE IN A DAY AT 8 AM 8PM.**
2. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. PANTODC 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
7. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. CILACAR 5 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. IVABRADINE 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

ARH1.0001233131		**Name**	Mr. K DURGAIAH
Patient Identifier	ARHIP56552	**Age**	58Yr 0Mth 2Days
Sex	Male	**Date of Admission**	10-Jul-2022
Date of Discharge			
MLC No			
Address	GODAVARIKHANI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 3
Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY		

RTA-TRAUMATIC BRAIN INJUTY
MULTIPLE HAEMORRHAGIC CONTUSIONS
TRAUMATIC SAH
FRACTURE LEFT CLAVICLE INVOLVING SHOULDER INJURY

Alleged h/o RTA slip and fall from 2 wheeler him self on 09/07/2022 followed by sustained injury to head
H/o LOC, vomiting

AT ADMISSION:

PR: 96/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94%

P/A: Soft, BS+

GCS- E3,V4,M6, B/l PERL

A 58 years old male patient DURGAIAH came with alleged h/o RTA slip and fall from 2 wheeler him self on 09/07/2022 followed by sustained injury to head, h/o LOC, vomiting. All necessary investigations were done and diagnosed as RTA-TRAUMATIC BRAIN INJUTY, MULTIPLE HAEMORRHAGIC CONTUSIONS, TRAUMATIC SAH, FRACTURE LEFT CLAVICLE INVOLVING SHOULDER INJURY. Managed conservatively. Patient's condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.0001177681		**Name**	Mr. T SATHISH		
	Patient Identifier	ARHIP56551		**Age**	40Yr 0Mth 15Days
	Sex	Male		**Date of Admission**	10-Jul-2022
	Date of Discharge				
	MLC No				
	Address	P H COLONY,.\D-1787,GODAVARIKHANI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 6
	Primary Consultant	Dr. RAMCHANDER TORREM			

ACUTE ON CKD
DCMP

C/o shortness of breath, swelling of feet, dysuria

AT ADMISSION:

PR: 102/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 98% on room air

P/A: Soft,

A 40 years old male patient Mr. SATHISH came with c/o shortness of breath, swelling of feet, dysuria. All necessary investigations were done and diagnosed as ACUTE ON CKD, DCMP. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. DYTOR 20 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. METOZ 10 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CARNIK-LC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. CALCI-CZ 0.25 MG **ONCE IN A DAY AT 2 PM**TO CONTINUE.
6. TAB. GEROZ –LP **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

7. SYP. POTKLOR 15 ml **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

REVIEW AFTER 5 DAYS IN NEPHROLOGY OPD

ARH1.0001233129		**Name**	Mr. T NARENDER		
	Patient Identifier	ARHIP56547		**Age**	55Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	09-Jul-2022
	Date of Discharge				
	MLC No				
	Address	PEGADAPALLY,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 4
	Primary Consultant	Dr. KRISHNA CHAITANYA			

CORONARY ARTERY DISEASE, EVOLVED AWMI

MILD LV DYSFUNCTION

NO HF, SR

CAG: SVD- mid LAD 99% stenosis done on 09/07/2022

PTCA TO LAD (2.75 X 28 MM XIENCE XPEDITION STENT) done on 09/07/2022

Complaint of chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 62/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96% on room air

P/A: Soft

A 55-year-old gentleman MR. NARENDER presented with complaints of chest pain since 4 days. On evaluation, ECG showed AWMI with ongoing pain, coronary angiogram done showed mid LAD 99% stenosis. PTCA to LAD with 2.75 x 28 mm Xience Xpedition stent done. Post dilated with 3 x 12 NC balloon. Good result. TIMI –III flow. Patient was asymptomatic and haemodynamically stable. Risk of stent thrombosis and sudden cardiac event, explained to patient. Need for 100% medication compliance explained to family and relatives.

DISCHARGE MEDICATION:

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1. TAB. AXCER 90 MG **TWICE IN A DAY AT 8 AM 8PM** TO CONTINUE.
2. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PANTODC 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
5. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. FLAVEDON MR 35MG **THRICE IN A DAY AT 8 AM 2PM, 8 PM** TO CONTINUE.
8. TAB. RANOZEX 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.

Review after 11 days in CARDIAC OPD with CBC, Renal Function Test.

ARH1.0001231305		**Name**	Mr. MAHESH J	
Patient Identifier	ARHIP56540		**Age**	40Yr 3Mth 26Days
Sex	Male		**Date of Admission**	08-Jul-2022
Date of Discharge				
MLC No				
Address	RAMAGUNDEM,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU 5
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

patient

CORONARY ARTERY DISEASE
UNSTABLE ANGINA, NORMAL LV FUNCTION, SR
CORONARY ANGIOGRAM DONE ON 09/07/22 –MID LAD MILD DISEASE
PLAN FOR MEDICAL MANAGEMENT
RISK FACTOR : HYPERTENSION

C/o chest pain and settings, shortness of breath on exertion

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 40 years old male patient MAHESH came with c/o chest pain and settings, shortness of breath on exertion
Fever, cough and cold. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NORMAL LV FUNCTION, SR , CORONARY ANGIOGRAM DONE ON 09/07/22 –MID LAD MILD DISEASE , PLAN FOR MEDICAL MANAGEMENT. Patient has history of chronic headache, neck pain for which neurophysician consultation was done and advised medication. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELMA-H 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. REXIPRA 5 MG ONCE DAILY AT 8PM FOR 15 DAYS.
6. TAB. NAPRA-D 500 MG IF PAIN FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001233095		**Name**	Mrs. KADARLA ALJAVVA
Patient Identifier	ARHIP56537	**Age**	61Yr 0Mth 3Days
Sex	Female	**Date of Admission**	08-Jul-2022
Date of Discharge	08-Jul-2022		
MLC No			
Address	SUDDAPALLI, PEGADAPALLI, JAGITIAL,Karimnagar,Telangana	**Ward/Bed No**	First Floor, Day Care, Bed no:DC 6
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	**Consultants**	
Surgeons	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
ATYPICAL CHEST PAIN,ANGINA EQUIVALENT, CORONARY ANGIOGRAM DONE ON 6/07/2022. ECTATIC CORONARIES WITH SLOW FLOW.--CICU	

C/o Chest pain, shortness of breath on exertion

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 61 years old female patient Mrs. KADARLA ALJAVVA came with c/o chest pain and settings, shortness of breath on exertion. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN,ANGINA EQUIVALENT, CORONARY ANGIOGRAM DONE ON 6/07/2022. ECTATIC CORONARIES WITH SLOW FLOW , PLAN FOR MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. FLAVEDON MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 1 MONTH /SOS

Narayana 56441 47

CORONARY ARTERY DISEASE + DOUBLE VESSEL DISEASE + S/P AWMI+DM+HTN,

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA] DONE ON 07/07/2022.

C/o retrosternal chest pain a/w sweating since 3 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 47 years old male patient Mr. NARAYANA presented to hospital with c/o retrosternal chest pain a/w sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + DOUBLE VESSEL DISEASE + S/P AWMI+DM+HTN, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA] DONE ON 07/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED_____

BMI is _____ kg/m2.

Sr. Creatinine report on 08.07.2022 1.1 mg/dl.

DISCHARGE MEDICATION:

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1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.

6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

8) TAB. CALPOL 500MG THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS.

9) TAB. PROLOMET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD